Goal 1

WHAT WE ENVISION FOR OUR COMMUNITY

Everyone in the region has access to health care when they need it, specifically for the region's top needs: behavioral health, oral health, vision care, and cardiovascular care

Community Outcomes

How we will know if we have made a difference

SHORT-TERM

- Increase connections to behavioral health, oral health, vision care and cardiovascular care
- Reduce unnecessary emergency department use for mental health, dental, and heart disease issues

INTERMEDIATE

- Increase use of routine, preventative primary, dental, and vision care
- Expand access to health, dental, and vision insurance coverage
- Increase the number of physicians, dentists, and mental health providers
- Reduce preventable hospital readmissions

LONG-TERM

- Improve incidence rates and outcomes for:
    - Depression
    - Anxiety
    - Suicide
    - Drug overdose
    - Youth drug use
- Reduce heart disease
- Reduce lifetime tooth decay
- Reduce preventable eye diseases

Priority Populations

The people and places experiencing significant health disparities

People from racial and ethnic minority groups (Black persons, Asian persons, American Indian persons), veterans and active-duty military, people who identify as LGBTQ+, people who are uninsured or underinsured, younger community members, and males.

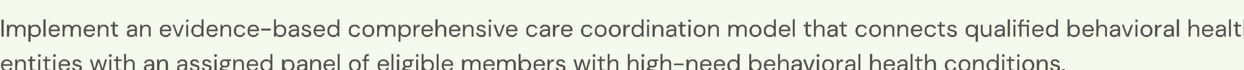
Goal 1

Priorities and Strategies

Evidence-informed actions to help achieve our goal

Cross-Cutting Strategies

1.0.1 Coordinate, strengthen, and expand behavioral health services in the region.



Implement an evidence-based comprehensive care coordination model that connects qualified behavioral health entities with an assigned panel of eligible members with high-need behavioral health conditions.

LEAD	Hospitals, Community mental health centers, Mental health Boards
PARTNERS	Community-based organizations
SAMPLE PILOT DESCRIPTION	According to the Substance Abuse and Mental Health Services Administration, "[c]are coordination is an activity rather than a service. The Care Coordination for Certified Community Behavioral Health Clinics (CCBHC) is responsible for all care coordination, whether it involves coordination within the CCBHC, with a designated collaborating organization (DCO), or with another entity identified in the statutory language related to care coordination."
REAL WORLD EXAMPLE	WakeMed Behavioral Health Network (WMBHN), developed in 2017, is a network of behavioral health, social service, and primary care providers to improve access and care coordination for patients suffering from mental and chronic health conditions. The network itself does not provide direct service, rather it helps coordinate the space between care/providers. Collaboration through this network can bring together experts, driven by clinical data, to identify solutions and create shared goals for success.
POTENTIAL IMPACT	Improvement of patient, practitioner, and provider satisfaction, better adherence to mental and behavioral health treatment plans, long-term health care cost savings, improved patient outcomes including reduced emergency department visits, smoother hospital referrals and time to treatment, and reduced length of stay and readmissions.
TIMELINE FOR IMPLEMENTATION	12+ months

Priority 1.1

Establish a consistent continuum of care across health systems that centers the patient and adapts to changing needs across their lifetime

Featured Strategies

1.1.1 Expand comprehensive primary care and emergency department care teams to include social workers and strengthen the coordination between all care areas.

Care coordination in the primary care practice and emergency department involves deliberately organizing patient care activities and sharing information between all parties concerned with a patient's care to achieve safer and more effective care. This shift is central to incorporating a focus on social determinants of health as part of all patients' health care plans.

LEAD	Emergency Medical Services (EMS), Health care organizations (Community Health Centers, Health Systems, Charitable Clinics)
PARTNERS	Social service agencies, community-based organizations, insurance providers (payers)
SAMPLE PILOT DESCRIPTION	EMS sees the need to include more primary care in their work, and decides to coordinate more closely by creating new communication channels, collaborative training programs, and joint services. Over time, the partnership leads to patients' needs and preferences being communicated at the right time to the right people, improving the delivery of safe, appropriate, and effective care.
REAL WORLD EXAMPLE	The Emergency Department Care Coordination (EDCC) Program ConnectVirginia Health Information Exchange is a statewide real-time communication and collaboration program. EDCC partners include health care providers and clinical and care management personnel for patients receiving services in Virginia to improve patient care services. 106 hospital EDs are live and participating on the network. The Virginia General Assembly established the EDCC Program to respond to the overutilization of emergency departments seen throughout the country. All health plans (3.4 million lives), multiple clinics, accountable care organizations, managed care entities, community services boards, federally qualified health centers, and skilled nurse facilities have already been onboarded or are onboarding.
POTENTIAL IMPACT	Reduce emergency department admissions, improve quality of chronic disease management, improve patient satisfaction, and better access to specialty care
TIMELINE FOR IMPLEMENTATION	6-9 months

Featured Strategies

1.1.2 Expand the availability of Community Health Workers in our region to help patients connect to and navigate services, particularly for mental health crises and oral trauma.

Community Health Workers (CHWs) can effectively deliver evidence-based treatments (EBTs) to meet the needs of communities with access and utilization disparities. CHWs may mobilize to step into the role of primary providers of EBTs in settings with severe workforce shortages. Still, even in higher-resourced settings, they may be involved in EBT delivery for individuals with lower levels of need, such as those who would benefit from mental health preventive services. CHW-delivered prevention and early behavioral intervention services would allow trained mental health professionals to focus their expertise on people who require more intensive services.

LEAD	Pathways Community Hub Model
PARTNERS	Hospitals, Community Health Centers, Federally Qualified Health Centers, Mental health providers, Foundations, Insurance Providers
SAMPLE PILOT DESCRIPTION	CHWs become essential members of the medical delivery system who are most likely to see underserved populations with limited or no access to dental services. CHWs can assist patients with accessing dental services. The CHWs then have the capacity to incorporate oral health information and the provision of preventive oral health services into their day-to-day practice. In addition, dental professionals can serve as key players in detecting chronic diseases such as diabetes, hypertension, and hypercholesterolemia in dental practices.
REAL WORLD EXAMPLE	The Maryland Regional Oral Health Pathways project utilizes CHWs to educate patients on dental hygiene and oral health. According to the Rural Health Information Hub, Maryland Regional Oral Health Pathways is "just one of many alternative dental workforce models that states are exploring to help reduce oral health disparities in rural America."
POTENTIAL IMPACT	Improve clinical outcomes and decrease hospital readmission rates and costs
TIMELINE FOR IMPLEMENTATION	3-6 months

Featured Strategies

1.1.3 Equip paramedics and emergency departments with access to electronic health records to expand a patient care team's access to primary care and behavioral health history.

Emergency Medical Services (EMS) utilize Electronic Health Record (EHR) integration to improve patient care through the health information exchange (HIE) between EMS and Emergency Department (ED) personnel.

LEAD	Health care systems (Emergency departments), Health Information Exchange
PARTNERS	First responders
SAMPLE PILOT DESCRIPTION	EMS works to establish access to patients' records via the HIE to improve care transitions and care coordination for first responders. The EMS personnel can then utilize their HIE connection to access patient EHRs for better-informed prehospital clinical decision-making that significantly impacts patient health outcomes. They can then access the data from an HIE organization to determine if the patient has been recently hospitalized and view their health history.
REAL WORLD EXAMPLE	Search, Alert, File, and Reconcile model "emphasizes that many EMS providers presently do not have access to longitudinal patient EHRs because they are not connected to an HIE organization", according to EHR Intelligence. The health data exchange within the Search, Alert, File, and Reconcile model capabilities can optimize EMS services by offering crucial information regarding hospitalizations, medications, end-of-life decisions, and medical conditions during transitions of care.
POTENTIAL IMPACT	In emergencies, patients or their families may not provide reliable information to impact initial care decisions and long-term outcomes. EHR access can reduce the threat of significant patient harm during rapid clinical decision-making in care transitions outside of the hospital setting. Health data exchange capabilities can optimize EMS services by offering crucial information regarding hospitalizations, medications, end-of-life decisions, and medical conditions during care transitions. Hospitals can ensure better care coordination by providing EMS personnel access to patient EHRs through an HIE connection. In contrast, patients are being transported from the site of an emergency to the receiving hospital. This vital pre-hospital care can mean the difference between life and death.
TIMELINE FOR IMPLEMENTATION	6-12 months

Featured Strategies

1.1.4 Provide on-demand crisis intervention services where a behavioral health crisis is occurring.

During crises, the more proximate and immediate the intervention, the better. On-demand and mobile crisis intervention services can help increase the speed and efficacy of treating behavioral health crises as they occur.

LEAD	Behavioral Health Providers
PARTNERS	Higher Educational Institutions, Hospitals, Federally Qualified Health Centers, Emergency Medical Services
PILOT DESCRIPTION	Mobile crisis response teams are groups of two or more crisis counselors that are centrally available to reach any person in their service areas in their home, workplace, or any other community-based location of the individual. Mobile crisis response teams serve a broad range of people in less-acute crises. Still, they can refer individuals to crisis receiving and stabilization facilities should they need a higher level of care.
REAL WORLD EXAMPLE	Families of children up to age 22 who are facing a behavioral health challenge or crisis situation can contact Mobile Response and Stabilization Services (MRSS) to get help within an hour any time of the day or night, seven days per week. Patients can also receive up to 45 days of intensive, in-home services and linkage to ongoing support. MRSS team may provide safety assessments, de-escalation, peer support, and skill-building.
POTENTIAL SUPPLEMENTAL POLICIES	Expansion of Mobile Response and Stabilization Services to support adults
POTENTIAL IMPACT	Reduce costs associated with inpatient hospitalization and improve patient safety
TIMELINE FOR IMPLEMENTATION	12-24 months

Additional Strategies

For further details on additional strategies, including real world examples, see Appendix I.

1.1.5 Increase health care providers' expertise and skills, providing opportunities for patient education, ensuring that patient care is team-based, and using registry-based information systems.

Using shared decision-making and patient education, clinicians can integrate patients into treatment decisions better by using team based care. This strategy will tap the patient as the expert on their care and lifestyle preferences that must consider before ordering certain therapies.

LEAD	Primary care organizations, Federally qualified health centers
PARTNERS	Schools

Policy/Advocacy

1.1.6 Collaborate with payers to secure reimbursement for social workers.

Care management services, including social workers who may not directly see patients but provide essential services in the continuity of care, have difficulty getting reimbursed for services provided in primary care settings. It is critical to address that gap.

LEAD	Insurance providers
PARTNERS	Community-based organizations, health care providers, and government entities

1.1.7 Advocate for improving the payment model for underinsured or uninsured people, ensuring providers are willing to participate in alternative payment models.

Well-designed, patient-centered alternative payment methods can provide significant opportunities to improve the quality and outcomes of patients' care in ways that also lower health care spending.

LEAD	Insurance providers
PARTNERS	Health care providers, health care organizations

Priority 1.2

Eliminate barriers to access and increase the use of preventive services for behavioral health, oral health, vision care, and cardiovascular care

Featured Strategies

1.2.1 Support ongoing efforts to reduce hypertension and stroke in the region through preventive services.

Like so many other conditions, heart disease is often best treated as early as possible through preventive measures. These efforts at education and self-care can help avoid more deadly progressions of heart disease.

LEAD	Community-based organizations focused on cardiovascular disease and/or health disparities
PARTNERS	Public Health Departments, Community Health Centers, Health Systems, Charitable Clinics
SAMPLE PILOT DESCRIPTION	Provide self-management support and education to patients to improve knowledge about wellness and self-efficacy, lower blood pressure, increase the regularity of vision and oral screenings, and increase medication adherence.
REAL WORLD EXAMPLE	The HealthCare Connection provides self-measured blood pressure monitoring devices to enable patients to measure their blood pressure outside of a clinical setting. The HealthCare Connection's team provides one-on-one counseling, virtual or telephonic support tools, and education for patients. This strategy provides patients with high blood pressure with quality and accessibility of care and improvement of blood pressure control.
POTENTIAL SUPPLEMENTAL POLICIES	Address other manageable chronic illnesses (e.g., cholesterol, diabetes)
POTENTIAL IMPACT	Reduced incidence of hypertension and stroke and related complications, improved adherence to preventive lifestyle measures and primary care
TIMELINE FOR IMPLEMENTATION	3-6 months

Featured Strategies

1.2.2 Train hospital partners with Community Health Workers in clinical settings in partnership with the Pathways Community Hub Model.

Community Health Workers' efficacy is dependent on the quality and scope of their training. The Pathways Community Hub Model provides an excellent foundation for CHWs to be most effective in their work.

LEAD	Pathways Community Hub Model
PARTNERS	Community Health Centers, Health Systems, Charitable Clinics, Community-based organizations, Insurance Providers
SAMPLE PILOT DESCRIPTION	Collaborate with Community-based organizations to conduct universal training for CHWs in the region.
REAL WORLD EXAMPLE	Health Care Access Now conducts classroom training that addresses the core competencies in health, including knowledge of social service resources, communication skills, advocacy, CPR certification, lifespan development, and basic community health worker skills.
POTENTIAL IMPACT	More consistent services from Community Health Workers, better community access to needed care and social services resources
TIMELINE	3-6 months

1.2.3 Become a care coordination agency within the Pathways Hub Model.

Care coordination agencies (CCAs) would facilitate care coordination in the primary care practice by sharing information among the patient's care team as well as designing and coordinating all patient care-related activities using the Pathways Hub model to achieve safer and more effective care.

LEAD	Pathways Community Hub Model
PARTNERS	Partners that become care coordination agency

Featured Strategies

SAMPLE PILOT DESCRIPTION	Conducting monthly in-person/virtual visits with the client to identify needs, opening relevant Pathways, and completing health and social service Pathways to address needs. CHWs are to meet at least monthly with each client and document each meeting in the Pathways Community Hub Model data system.
REAL WORLD EXAMPLE	Deploy CHWs within various settings to provide active community-based care coordination. Providing active care coordination services to at-risk community members includes enrolling the new client in the Hub through in-person/virtual meetings to assess needs and risk factors.
POTENTIAL IMPACT	Increase access and care coordination to more patients within the community to improve health outcomes
TIMELINE	12-24 months

1.2.4 Expand partnerships between regional transportation organizations and health systems to increase patient access to transportation.

Hospitals and health systems partnering with ride-sharing businesses and other transportation services can improve health outcomes, increase patient satisfaction, and increase revenue.

LEAD	Regional transportation provider
PARTNERS	Community-based organizations
SAMPLE PILOT DESCRIPTION	A hospital establishes a partnership with its local transit authority in order to identify and solve for gaps in current fixed-route and on-demand services which serve its patients.
REAL WORLD EXAMPLE	In early 2022, CVS Health partnered with Uber Health to provide free rides to health care appointments and job training for residents of Columbus's Linden neighborhood.

Featured Strategies

POTENTIAL SUPPLEMENTAL POLICIES	Advocate for federal programs that set the stage for state and local coordination. The Coordinating Council on Access and Mobility, National Centers for Mobility Management, and Centers for Medicaid and Medicare Services set guidelines and provide grant funding to encourage coordination. States choose their schemes for transportation coordination, and some choose a mix of service types. Local coordination requires both political support and on-the-ground responsibility for sharing resources.
POTENTIAL IMPACT	Cost savings for coordination are significant for all transportation solutions. Brokerages, transit voucher or reimbursement programs, and transportation networks reduce costs and produce significant returns where coordination programs require an initial capital investment.
TIMELINE	9-12 months

Additional Strategies

For further details on additional strategies, including real world examples, see Appendix I.

1.2.5 Identify opportunities for patients to obtain medication while at the physician's appointment.

Provide medication therapy experts within the health care system after being seen by a medical professional. Pharmacists are committed to patient care by ensuring the safe and effective use of medications.

LEAD	Health care organizations, Insurance providers
PARTNERS	Community-based organizations

1.2.6 Increase school-based health and dental clinics in prioritized neighborhoods.

According to the Health Resources and Services Administration, "[s]tudents and their families rely on school-based health centers to meet their needs for a full range of age-appropriate health care services, including primary medical care, mental/behavioral health care, dental/oral health care, health education and promotion, substance abuse counseling, case management, [and] nutrition education."

LEAD	Local experts on School Based Health Centers
PARTNERS	Health departments, Foundations

1.2.7 Expand telehealth services to all areas of care (primary care, specialists, behavioral health, dental, and vision care).

Telemedicine includes telehealth and other virtual services which allow patients to visit with clinicians remotely. According to healthaffairs.org, "[i]nnovative uses of this kind of technology in the provision of health care are increasing with advances in telehealth platforms and remote patient monitoring technology. New mobile health apps and wearable monitoring devices help track patients' vitals, provide alerts about needed care, and help patients access their physicians."

LEAD	Government entities
PARTNERS	Health care organizations, Health care providers

Policy/Advocacy

1.2.8 Advocate for the improvement of existing medical paratransit through Medicare and Medicaid.

Hospitals and health care providers to track data regarding the successful use of state Medicaid and Medicare transportation services to and from health care providers and utilize this data to advocate for the improvement of these services.

LEAD	Health care organization
PARTNERS	Government entities

1.2.9 Advocate for insurance coverage for telehealth services not already covered.

Use telehealth efforts to reduce the number of in-clinic visits and still maintain important monitoring and follow-up care. Increasing telehealth services is especially important to patients who lack transportation, yet insurance coverage can be a major barrier for many potential patients.

LEAD	Regional Health Improvement Collaborative, Community-based organizations
PARTNERS	Insurance providers

Developing Strategies

The strategies below are newer, and as a result have less available data regarding best practices and implementation, but demonstrate a positive evidence base for efficacy thus far.

- Streamline prescription access and payment systems for those without insurance or with limited insurance assistance, including those using coupons to offset prescription costs.
- Increase incentives for health care professionals to work in rural areas or with underserved populations (e.g., school loan payments).
- Advocate to streamline and improve Medicare and Medicaid prescription payment processes to ensure timely access to medication.
- Collaborate with payers to increase dental care reimbursements.

Priority 1.3

Foster health education and health literacy

Featured Strategies

1.3.1 Work to raise overall public awareness of the link between quality dental, vision, behavioral health, and cardiovascular care and positive health outcomes.

Dental, behavioral, and cardiovascular health awareness should begin at a very young age. Primary care physicians and specialists should provide continuous health education on quality care.

LEAD	Public Health Departments, Community-based organization specializing in grassroots education
PARTNERS	Dental Professionals, Behavioral health professionals, Cardiovascular specialists
SAMPLE PILOT DESCRIPTION	Dental health awareness should be assessed by adult dentists. If patients are aware of their dental health, they will know what dental practices they should maintain to have healthy teeth.
REAL WORLD EXAMPLE	The American Dental Association sponsors the National Children's Dental Health Month during February to raise awareness among children and their parents about dental health. The campaign focuses on instilling in the young the importance of regular tooth brushing and dental examinations to prevent dental problems.
POTENTIAL IMPACT	Better overall, holistic health outcomes for patients, reduced health care costs, improved adherence to treatment plans
TIMELINE	6-12 months

Featured Strategies

1.3.2 Educate patients, employers, and health care providers about dental, vision, and behavioral health insurance plans.

Educating patients, employers and health care providers so that they better understand their insurance coverage and benefits is crucial for creating a great patient experience.

LEAD	Public Health Department, Local experts in community engagement, Health care providers
PARTNERS	Federally Qualified Health Centers, Community health centers, Hospitals
SAMPLE PILOT DESCRIPTION	Medical professionals should clearly communicate insurance plan details with their patients. In this way, patients will fully understand a practice's payment policy. Discussing the medical bills does not have to be overly complex, but a lack of insurance literacy among some patients makes this more difficult.
REAL WORLD EXAMPLE	Medical Mutual created Health Insurance Education programming including resources designed to help take the mystery out of health insurance. They provide information regarding health insurance decisions for individuals in their families.
POTENTIAL IMPACT	Decrease the number of unpaid balances and create a better experience for patients
TIMELINE	3-6 months

Featured Strategies

1.3.3 Create and distribute health literacy materials in priority zip codes.

Health literacy is the ability to find, communicate, and understand basic health services and information. Ensure health literacy materials are distributed through trusted grassroots organizations, are culturally and linguistically appropriate, and are provided in various formats (e.g., digital, live web-based, face-to-face).

LEAD	Community-based organizations
PARTNERS	Health care organizations, School systems
SAMPLE PILOT DESCRIPTION	A hospital collaborates with a local school system to create health literacy materials for high school students designed to increase their understanding of the role of primary care in overall health. These partners begin by learning about their intended audience's interests, needs, and values, in order to ensure materials are effective in both format and design. Once materials are drafted, these partners pretest them with the intended audience and make appropriate revisions to materials according to the findings of the pretest. They distribute the materials, and follow up three to six months later to assess the efficacy of this initiative by surveying relevant population members.
REAL WORLD EXAMPLE	An organization identified the ten states with the most COVID-19 cases and selected forty-two materials (i.e., webpages, infographics, and videos) related to COVID-19 prevention according to predefined eligibility criteria. We applied three validated health literacy tools including CDC Clear Communication Index to assess material understandability, actionability, clarity, and readability. The organization recommends using infographics and videos when possible, taking a human-centered approach to information design, and providing multiple modes and platforms for information delivery.
POTENTIAL IMPACT	Better health care utilization among target populations, improved prevention of some conditions, better management of chronic and other existent health conditions, improve health-related lifestyle choices
TIMELINE	6-9 months

Policy/Advocacy

1.3.4 Advocate for including preventive dental and vision health into general health promotion, school curricula, and activities.

School-based health education helps youth acquire functional health knowledge, and strengthens attitudes, beliefs, and practice skills needed to adopt and maintain healthy behaviors.

LEAD	Government Relations at Hospitals, Local Advocacy Organizations, and Schools
PARTNERS	Community-based organizations
SAMPLE PILOT DESCRIPTION	School curricula which include health-related content should contain learning outcomes directly related to students' acquisition of health-related knowledge, attitudes, and skills and are grade-level appropriate. Ensuring there is continuity between these lessons helps to ensure children adopt healthier behaviors that are likely to stick with them into adulthood.
REAL WORLD EXAMPLE	The Division of Pediatric Dentistry at The Ohio State University College of Dentistry states that "dental education has an opportunity to teach advocacy skills to future dentists, although advocacy training in predoctoral dental education has been largely ignored." They evaluated fourth-year dental student's attitudes toward advocacy, identified the type and extent of advocacy experiences during dental school, and assessed their future intentions to engage in advocacy. According to their findings, "[d]ental students with advocacy experience are more likely to report intentions to participate in advocacy as dentists. Dental education has a critical role in preparing future dentist-advocates."
POTENTIAL IMPACT	Improved health knowledge among children, better adherence to health care appointments and treatments later in life, healthier behaviors
TIMELINE	12-24 months

Policy/Advocacy

1.3.5 Advocate for standard plan summary for Medicaid benefits for easy access for providers and patients.

To help individuals compare the different features of health benefits and coverage, the Affordable Care Act requires group health plans and insurance companies to provide those covered with a summary of benefits and coverage (SBC) that accurately describes their coverage under the plan. Along with this SBC, group health plans and insurance companies must also provide a Uniform Glossary to explain standard medical and insurance-related terms.

LEAD	Government Relations at Hospitals, Local Advocacy Organizations
PARTNERS	Community-based organizations (lobbying)
SAMPLE PILOT DESCRIPTION	The SBC reflects a health plan's benefits, anticipated costs for the patient, and covered health care services. SBCs also explain other unique features, such as cost-sharing rules, and include descriptions of the limits of a person's coverage in plain, jargon-free terminology.
REAL WORLD EXAMPLE	The Dental and Optometric Care Access Act, or DOC Access Act, according to the ADA, is "...bipartisan legislation prohibits dental, and vision plans from setting the fees network doctors may charge for services not covered by the insurers. It also protects patients and brings needed equity to insurer/provider contracting. Even though 42 states have passed laws limiting interference with the dentist-patient relationship, many dental and vision plans are federally regulated, so insurers can claim they are exempt. Passage of this bill will help align the federal government with what's happening across the country. It would also balance contract negotiations between providers and large dental insurance companies."
POTENTIAL IMPACT	Individuals are more aware of their benefits and can accurately describe the benefits and coverage under the plan, better access to health services allows people to be more productive and ensures better education outcomes for children, while mitigating the risk that a person or family could be pushed into poverty by a health-related expense
TIMELINE	12-24 months