

SHIP STRATEGIES	SIM DRIVERS
<p><b><i>Advocacy and Policy</i></b></p> <p><u>Chronic Disease</u></p> <ul style="list-style-type: none"> <li>• Adopt and implement policies to support insurance coverage for chronic disease self-management programs.</li> <li>• Explore insurance incentives to promote employee wellness programs (e.g., State Health Enhancement Program insurance plan as a model).</li> <li>• Explore insurance incentives for non-smokers.</li> </ul> <p><u>Health Systems</u></p> <ul style="list-style-type: none"> <li>• Provide incentives for Patient-Centered Medical Home (PCMH) accreditation.</li> <li>• Support policy change to align payment systems with population health, not just illness care</li> </ul>	<p>Value Based Insurance Design</p> <p>Advance Medical Homes and PCMH+</p> <p>Public Health Priorities Quality Measures</p>
<p><b><i>Education and Training</i></b></p> <p><u>Chronic Disease</u></p> <ul style="list-style-type: none"> <li>• Ensure that healthcare providers have the tools to promote healthy lifestyle behaviors (healthy eating, active living, avoiding the use of tobacco products, limiting exposure to secondhand smoke, etc.) and to make referrals to community resources.</li> <li>• Train and develop teams of community health workers to ensure consistent follow up and connections between patients and providers, and to enhance referrals and treatments.</li> </ul>	<p>Community and Clinical Integration Program</p> <p>Community Health Workers Initiative</p>
<p><b><i>Partnership and Collaboration</i></b></p> <p><u>Chronic Disease</u></p> <ul style="list-style-type: none"> <li>• Foster collaboration among community-based organizations, the education and faith-based sectors, independent living centers, businesses, and clinicians to identify underserved groups and implement programs to improve access to preventive services.</li> </ul>	<p>Community and Clinical Integration Program</p> <p>Community Health Collaborative</p>
<p><b><i>Planning &amp; Development</i></b></p> <p><u>Chronic Disease</u></p> <ul style="list-style-type: none"> <li>• Develop a sustainable infrastructure for widely accessible, readily available self-management interventions that link community and clinical settings and make use of lifestyle intervention professionals such as registered dietitians, exercise physiologists, and social workers.</li> <li>• Establish clinical-community linkages that connect patients to self-management education and community resources.</li> </ul> <p><u>Health Systems</u></p> <ul style="list-style-type: none"> <li>• Explore and support models and programs that coordinate community services and link primary and specialty care.</li> <li>• Support telemedicine for specialty care links.</li> </ul>	<p>Community and Clinical Integration Program</p> <p>Health Equity Improvement</p> <p>Community and Clinical Integration Program</p> <p>e-Consult Standards</p>
<p><b><i>Communications and Surveillance</i></b></p> <p><u>Chronic Disease</u></p> <ul style="list-style-type: none"> <li>• Improve reporting/data for public accountability.</li> </ul> <p><u>Health Systems</u></p> <ul style="list-style-type: none"> <li>• Make use of new sources of data (i.e., the All Payer Claims Database (APCD)) to provide a critical healthcare decision making tool for all residents and a means for providers to evaluate their care delivery.</li> </ul>	<p>SIM Public Scorecard</p>