MAPPING OF THE SIM POPULATION HEALTH OPERATIONAL PLAN WITH THE SIM DRIVER DIAGRAM

B. Detailed SIM Operational Plan **1. Plan for Improving Population Health** ● Background **1.1 Purpose of the Population Health Plan** ● Goals and Objectives ● Promote Health Policy change ● Promote Health Systems and Environmental change ● Improve Health Outcomes	**PURPOSE OF THE POPULATION HEALTH PLAN** **Aim:** Improve Population Health **1st Driver:** Promote change in policy, systems and the environment to address socioeconomic factors that impact health
1.2 Community Health Improvement Measurement ● Population Health Metrics System [3] ● Root Causes and Barrier Analysis of Population Health Priority Indicators [4] ● High Burden of Disease Areas [6]	**2nd Driver:** Identify reliable & valid measures of community health improvement [1, 5] **Acc. Target:** Community Health Measures Identified for Target Communities [2]
1.3. Design and Implement a Prevention Service Center Model Demonstration Site ● Baseline Assessment of Provider Capacity for PSC's and Community Collaboration [7] ● Prevention Service Centers Design and Prevention Services Menu [8]	**2nd Driver:** Develop a design and implement a Prevention Service Model **Acc. Target:** Demonstration of PSC's
1.4. Propose an implementation design of a Health Enhancement Community ● Health Enhancement Communities [10, 11] ● HEC Design Considerations ● Opportunities for Financial Sustainability of HECs [9]	**2nd Driver:** Develop a detailed design of a Health Enhancement Community (HEC) model that includes a financial incentive model to reward communities for health improvement **Acc. Target:** Detailed Design Plan for HEC's designation
C. General SIM Operational and Policy areas **1. SIM Governance, Management Structure and Decision-making Authority** ● g. Population Health Council (supported by the Department of Public Health) **2. Stakeholder Engagement** ● Participating Public Health Sector and Key SIM Activities ● Risks of Not Engaging Public Health Sector Stakeholders	**2nd Driver:** Engage Local And State Health, Government, And Community Stakeholders To Produce A Population Health Plan **Acc. Target:** Develop Population Health Assessment Develop Population Health Plan

OPERATIONAL COMPONENTS

1. Develop Population Health Assessment
2. Community health measures identified for target communities
3. Provide data and enabling methods to select and maintain metrics of Population Health
4. Conduct a root cause and barrier analysis of population health priority indicators
5. Define trends and improvement targets for tobacco use, obesity and diabetes and other selected population health indicators
6. Identify priority areas with highest burden of disease and community institutional capacity to implement prevention initiatives
7. Conduct statewide scan to identify entities able to provide evidence-based community-prevention services
8. Design Prevention Service Centers, research evidence -based interventions and finalize PSC's service menu
9. Identify funding options & federal authority to support Prevention Service Centers and Health Enhancement Communities
10. Conduct research and develop conceptual model of HEC
11. Establish a planning team and guiding principles for Health Enhancement Communities (HEC's)

SHIP STRATEGIES	SIM DRIVERS
Advocacy and Policy	
Chronic Disease • Adopt and implement policies to support insurance coverage for chronic disease self-management programs. • Explore insurance incentives to promote employee wellness programs (e.g., State Health Enhancement Program insurance plan as a model). • Explore insurance incentives for non-smokers. Health Systems • Provide incentives for Patient-Centered Medical Home (PCMH) accreditation. • Support policy change to align payment systems with population health, not just illness care	Value Based Insurance Design Advance Medical Homes and PCMH+ Public Health Priorities Quality Measures
Education and Training	
Chronic Disease • 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. • 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.	Community and Clinical Integration Program Community Health Workers Initiative
Partnership and Collaboration	Community and Clinical Integration Program Community Health Collaborative
Chronic Disease • 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.	
Planning & Development	
Chronic Disease • 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. • Establish clinical-community linkages that connect patients to self-management education and community resources. Health Systems • Explore and support models and programs that coordinate community services and link primary and specialty care. • Support telemedicine for specialty care links.	Community and Clinical Integration Program Health Equity Improvement Community and Clinical Integration Program e-Consult Standards
Communications and Surveillance	
Chronic Disease • Improve reporting/data for public accountability. Health Systems • 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.	SIM Public Scorecard