

2020-2021 strategic plan

pillar

definition

measure

collaborations in care



Develop and implement co-management programs to facilitate alignment across the continuum of care.

- Implement headache and asthma co-management across the network
- Collaborate with Dayton Children's Specialty Group, ED, UC, and Kids Express on newly unveiled co-management programs to reduce potentially avoidable visits
- Create baseline data and dashboards for new co-management programs
- Monitor and track co-management implemented programs
- Secure MOC credit for new co-management programs and Call First project

Quality committee to provide oversight in areas of focus based on data review and provider input

right place, right care



Develop and implement education and a common language to encourage patients to utilize the best site of service for care.

Identify best practice in primary care for addressing potentially avoidable ED visits.

- Reduce potentially avoidable emergency department visits for DCHP patients from baseline by 5 points
- Standardize processes for communication between ED, PCPs and families for follow-up after ED visit
- Collaborate with hospital leadership to reduce potentially avoidable ED visits by creating appropriate access points

Quality committee will drive data review and office leadership will drive operational benchmarking

behavioral health



Develop a model for supporting the behavioral health within the primary care setting.

- Complete practice level readiness assessments for integrating behavioral health in primary care
- Develop use of a behavioral health model in primary care
- Define the scope of a program, short term needs and long term success
- Implement pilot for standardizing depression screening across the network
- Assess the need for and hire additional resources to support behavioral health in primary care
- Offer training opportunities related to behavioral health support and prevention for PCPs and mental health professionals

A focused workgroup will provide strategic oversight

pillar

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financial vitality



Demonstrate performance on financial and quality indicators to tell our story to payers and other potential partners.

Continue to develop payer and other relationships to support the work of the providers in the network.

- Partner with payers to understand and implement value-based reimbursement
- Fully utilize Wellcentive to provide cost performance dashboards to support payer conversations that drive change
- Support network practices in other value based programs ie: Comprehensive Primary Care (CPC) Program, CPC Kids, Episodes of Care (EOC) and Partners for Kids (PFK)
- Evaluate all payer options including a Medicaid payer
- Develop and implement a performance incentive distribution model for shared savings
- Secure grant funding to support financial vitality within the network

Finance committee will provide strategic oversight

care transformation



Use data to develop a care management strategy to support the network's population health programs.

Utilize risk stratification model to develop complex care coordination.

- Drive changes based on Wellcentive and payer scorecards and dashboards for clinical quality measures
- Aggregate and leverage big data for analysis, risk stratification and reporting
- Develop strategies to support primary care practices based on their needs and the network's programs
- Create care management strategy for high and rising risk populations

Internal team will provide data insights to inform program development

