Connecticut SIM Logic Model: Legend

Categories

- **Inputs**: A set of defined resources that will enable activities to be accomplished
- **Activities**: Defined set of activities conducted to address the health care issues
- **Outputs**: Evidence produced from completed activities
- **Impacts**: Overall, statewide changes that will occur as a result of completing activities

Acronyms

- **AMH**: Advanced Medical Home
- **AN**: Advanced Networks
- **BH**: Behavioral Health
- **CCIP**: Community and Clinical Integration Program
- **CCT**: Comprehensive Care Team
- **CHW**: Community Health Worker
- **CQM:** Clinical Quality Measure
- **FQHCs**: Federally Qualified Health Centers
- **HEC**: Health Enhancement Community
- **HIT:** Health Information Technology
- **MH**: Medical Home
- **MQISSP**: Medicaid Quality Improvement and Shared Savings Program
- **PSC**: Prevention Service Center
- **TA**: Technical Assistance
- **VBID**: Value-Based Insurance Design
- **VBP**: Value-Based Payment

Connecticut SIM Logic Model: Cover Page

Inputs

SIM Grant Funds

Multi Stakeholder Workgroups

Regulatory Levers

Existing health information technology assets

Consumer Engagement

Activities

Strengthen healthcare delivery *(primary driver)*
- Community and Clinical Integration Program (CCIP)
- Advanced Medical Home (AMH) program
- Community Health Worker Promotion
- Enable the exchange of health information, tools for efficient communication and coordination; tools for analytics

Promote payment models that reward improved quality, care experience, health equity and lower cost *(primary driver)*
- Medicaid Quality Improvement & Shared Savings Program (MQISSP)
- Quality Alignment on core quality measures
- Enable clinical quality measure (CQM) production for VBP

Engage consumers in healthy lifestyles, preventive care, chronic illness self-management, and healthcare decisions *(primary driver)*
- Value-Based Insurance Design promotion
- Forums, listening sessions
- Public scorecard

Promote policy, systems, & environmental changes, while addressing socioeconomic factors that impact health *(primary driver)*
- Design and designate Health Enhancement Communities
- Develop financial incentive model to reward health enhancement communities for health improvement
- Designate Prevention Service Centers (PSCs)
- Conduct root cause and barrier analysis
- Implement community health improvement measures
- Engage health, government, and community stakeholders in multi-stakeholder governance model

Promote payment models that reward improved quality, care experience, health equity and lower cost *(primary driver)*
- Quality Alignment on preventative measures for VBP

Engage consumers in healthy lifestyles, preventive care, chronic illness self-management, and healthcare decisions *(primary driver)*
- Value-Based Insurance Design promotion

Outputs

Strengthen healthcare delivery
- 15 ANs and 1 FQHC succeed in CCIP standards by 2019
- ANs have 300+ practices achieve AMH by 2019
- AN practices and community partners have timely access to health information, coordinate and communicate efficiently as a team, and identify high risk patients and improve performance with subpopulations
- Policy framework developed for CHW workforce by 2017 and toolkit for utilization by 2017, with implementation to follow

Promote payment models that reward improved quality, care experience, health equity and lower cost
- 400,000+ lives in MQISSP by 2019, 88% by 2020
- 88% of CT population goes to PCP responsible for quality and total cost of care by 2020
- Payers better aligned on quality measures used in VBP
- Payers access CQMs from clinical systems in automated way

Engage consumers in healthy lifestyles, preventive care, chronic illness self-management, and healthcare decisions
- 87% of insured population in VBID by 2020
- Twelve public meetings held by 2019
- Consumers are empowered with AN performance data to inform their decisions regarding choice of AN

Promote policy, systems, & environmental changes, while addressing socioeconomic factors that impact health
- 1-2 HECs are designed and plan for designation
- Comprehensive financial model for HEC developed by Q2 2017
- 2-3 PSCs designated
- Communities track & accountable for community health measures
- Early buy-in, successful program design, and establishment of long-term support

Promote payment models that reward improved quality, care experience, health equity and lower cost
- 88% of CT population goes to PCP responsible for the quality and cost of their care by 2020
- Payers better aligned on preventative CQMs used in VBP

Engage consumers in healthy lifestyles, preventive care, chronic illness self-management, and healthcare decisions
- 87% of insured population in VBID by 2020

Impact

Improve Health Care Quality, while Reducing Disparities

Colorectal screening; mammograms; diabetes care –A1c tests ; hypertension medication; mental health days; all-condition readmissions; ambulatory care sensitive condition admissions; regular source of care; well child visits; premature death rates

Reduce **disparities** in: regular source of care; readmissions, admissions, well-child visits, cancer screenings, A1c tests, taking hypertension medication, consumer experience survey results +

Improve Health Care Sustainability & Affordability

1-2% percentage point reduction in annual healthcare spending growth

Improve Population Health, while Reducing Disparities

- Obesity rate
- Smoking rate
- Diabetes rate

Reduce **disparities** in obesity rate, smoking and diabetes rates

Improve Health Care Sustainability & Affordability

1-2% percentage point reduction in annual healthcare spending growth

*baselines may change based on updated data

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Connecticut SIM Logic Model: Drill Down Page 1 of 2

Inputs

SIM Grant Funds

Multi Stakeholder Workgroups

Regulatory Levers

Existing health information technology assets

Activities

ANs / FQHCs

Strengthen healthcare delivery *(primary driver)*

1. CCIP: Provide TA/awards to MQISSIP networks to achieve standards in:
   a) Comprehensive Care Management (e.g., identify at-risk patients; connect to care team with community health worker (CHW); care plan; exchange health information across settings, etc.)
   b) Health Equity Intervention (e.g., analyze clinical data by race/ethnicity; implement intervention with CHW support; linkages to community resources, etc.)
   c) Behavioral Health Integration (e.g., identification; screening tool; referral; training; sharing of care plan, etc.)
   d) Community Health Collaboratives
   e) Elective capabilities: E-Consult, Oral Health Integration, Comp Med Mgmt
2. AMH Program: Provide technical assistance and learning collaborative to non-medical home practices in Advanced Networks to achieve:
   a) PCMH standards: Patient-Centered Access, Team-based Care, Population Health Management, Care Management and Support, Care Coordination and Care Transitions, Performance Measurement and Quality Improvement,
3. Create and promote model to integrate Community Health Workers
4. HIT

ANs / FQHCs

Promote payment models that reward improved quality, care experience, health equity and lower cost *(primary driver)*

1. Medicaid Quality Improvement & Shared Savings Program (MQISSP) provides incentives for performance on quality measures and has care coordination other requirements
2. Promote alignment among payers on core quality measures for use in value-based payment contracts that reward improvement in:
   a) preventative services (cancer screening, weight assessment, tobacco screening, mammograms, well-child visits)
   b) chronic care services (diabetes, asthma, hypertension)
   c) behavioral health services (depression screening & remission, ADHD mgmt);
   d) effective management of individuals with complex care needs (ED use, readmissions)
3. Deploy HIT solution that can support the extraction of clinical data to allow payer adoption of clinical measures for value-based payment

Employers, Consumers

Engage consumers in healthy lifestyles, preventive care, chronic illness self-management, choice of AN and other healthcare decisions *(primary driver)*

1. Engage employers to adopt VBIDs that reward use of disease management & treatment support services, high value ANs who adhere to evidence-based treatment, high value treatment services
2. Hold listening sessions, public forums, and stakeholder meetings
3. Create public common scorecard that makes healthcare quality transparent

Outputs

Strengthen healthcare delivery *(primary driver)*

- 16 ANs/FQHCs achieve CCIP standards by 2019
- ANs have 300+ practices achieve AMH by 2019
- ANs/FQHCs share health information efficiently across clinical and community partners
- ANs/FQHCs use e-referral, tracking and follow-up to effect clinical and non-clinical linkages to services and supports
- ANs/FQHCs receive timely information re: ADTs
- ANs/FQHCs effectively coordinate and communicate with inter-disciplinary team including patient, patient supports, clinical and non-clinical community partners
- AN/FQHC care teams have access to a comprehensive view of the patient and care plan
- AN/FQHC's analytic tools enable use of clinical systems to identify high risk populations and sub-population analyses (e.g., race, neighborhood, social factors) to support targeted continuous quality improvement
- Policy framework developed for the CHW workforce by 2017 and toolkit for utilization by 2017, with implementation to follow
- HIT TBD

Promote payment models that reward improved quality, care experience, health equity and lower cost *(primary driver)*

- 400,000+ Medicaid beneficiaries in MQISSP by 2019, 88% by 2020
- 88% of CT population goes to PCP responsible for quality and total cost of care by 2020;
- Payers better aligned on quality measures used in VBP
- Payers access CQMs from clinical systems in automated way and use for VBP

Engage consumers in healthy lifestyles, preventive care, chronic illness self-management, and healthcare decisions *(primary driver)*

- 85% of insured population in VBID by 2020 ; Consumers empowered to make healthier lifestyle decisions and engage in illness self-management
- Twelve public meetings held by 2019
- Consumers empowered with AN performance data to inform their decisions regarding choice of AN

Impact

Improve Health Care Quality

- **Colorectal screening:** 75.7% to 83.6%; for low income adults from 64.9% to 68.2%
- **Mammograms** for women ages 50+ in last two years from 83.9% to 87.7%
- **Optimal diabetes care :**–2+ annual A1c tests from 72.9% to 80.1%
- **Hypertension:** Adults with hypertension who take hypertension medication from 60.1% to 69.5%
- **Asthma ED use:** Children & adults from 73 to 64 per 10,000
- **Mental health days**
- **Risk-standardized all-condition readmissions:** from 15.9% to 13.1%
- **Ambulatory care sensitive condition admissions** : from 1,449 to 1,195 per 100,000
- **Adults who have a regular source of care:** from 83.9% to 93.0%
- **Children well child visits** for at-risk population: from 62.8% to 69.1%
- **Premature death rates** for adults due to cardiovascular disease from 889 to 540 per 100,000

Health Equity

- Reduce **disparities** in: regular source of care; readmissions, admissions, well-child visits, cancer screenings, A1c tests, taking hypertension medication, consumer experience survey results

Improve Health Care Sustainability & Affordability

1-2% percentage point reduction in annual healthcare spending growth

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Inputs

SIM Grant Funds

Multi Stakeholder Workgroups

Regulatory Levers

Existing health information technology assets

Activities

Communities

Promote policy, systems, & environmental changes, while addressing socioeconomic factors that impact health *(primary driver)*

1. Develop financial incentive model to reward Health Enhancement Communities (HECs) for health improvement
2. Design and designate HECs to target resources and facilitate coordination and collaboration among multiple sectors, including relationships among ACOs and community stakeholders
3. Designate Prevention Service Centers (PSC) to strengthen community-based health services
4. Conduct root cause and barrier analysis for tobacco, obesity, diabetes & identify evidence-based interventions
5. Engage health, government, and community stakeholders
6. Establish and implement reliable & valid measures of community health improvement to support community accountability

ANs / FQHCs

Promote payment models that reward improved quality, care experience, health equity and lower cost *(primary driver)*

1. Promote alignment among payers on core quality measures for use in value-based payment contracts that reward improvement in:
   a) preventative services (cancer screening, weight assessment, tobacco screening, mammograms, well-child visits)

Employers, Consumers

Engage consumers in healthy lifestyles, preventive care, chronic illness self-management, and healthcare decisions *(primary driver)*

1. Engage employers to adopt VBID health plans that reward use of preventative services

Outputs

Promote policy, systems, & environmental changes, while addressing socioeconomic factors that impact health *(primary driver)*

- Comprehensive financial model for HEC developed by Q2 2017
- 1-2 HECs are designed and designated
- 2-3 PSCs offering evidence-based community preventive services are designated
- Analysis completed and interventions identified for tobacco, diabetes & obesity
- Stakeholders are actively engaged in population health initiatives
- Reliable & valid measures of community health improvement are developed and implemented. Communities track and are accountable for community health measures.

Promote payment models that reward improved quality, care experience, health equity and lower cost *(primary driver)*

- Payers better aligned on quality measures used in VBP that focus on prevention

Engage consumers in healthy lifestyles, preventive care, chronic illness self-management, and healthcare decisions *(primary driver)*

- 85% of insured population in VBID by 2020 ; Consumers empowered to use preventative services and make healthier lifestyle decisions

Impact

Improve Population Health

- **Obesity:** in adults from 24.5% to 22.95%, children from 18.8% to 17.65%, a
- **Adults who smoke** to 14.40% and youth who smoke from 14% to 12.72%
- **Adult diabetes** to 7.86%
- %

Health Equity

- **Obese children in low income households** from 38% to 35.55%
- **Low income adults who smoke** from 25% to 22.43%
- **Low income adults with diabetes** from 14.3% to 11.32

Version 3.1 --- 2/24/2016