	VALUE BASED PAYMENT	CARE DELIVERY REFORM				CONSUMER EMPOWERMENT	POPULATION HEALTH			HEALTH IT	
	Commercial SSP & Medicaid PCMH+ Scorecard	**Community & Clinical Integration Program**	**Advanced Medical Home Program**	**PCMH+ elements**	**Community Health Worker Initiative**	**Value Based Insurance Design**	**Community Measures (2018)**	**Prevention Service Centers (2018)**	**Health Enhancement Communities (2019)**	**HIE/ADT/ eCQMs**	**HIT: Other (mobile apps, EHR SaaS, Care Analyzer)**
Individuals with Complex Health Needs	Readmission payment measure	Standard 1: comprehensive care management	Foundational PCMH skills	Employ a care coordinator/ assign care coordination activities	Enable CHW workforce that can integrate into care teams	Recommended: Complex case management program			TBD	Providers have access to comprehensive info about patients (eg ADTs); enable referral f/u	Care Analyzer allows identification of individuals with complex health needs
Diabetes: prevention and control	A1C control (NQF 0059) measure as core reporting (short term) and payment (long term) measure *	Standard 2: Health Equity Intervention focused on diabetes, HTN, or asthma	Foundational PCMH skills	Foundational PCMH skills	Ensure CHW workforce that can do diabetes prevention and control	Recommended: Obesity screenings, chronic disease management	Obesity incidence/ prevalence & up-stream indicators	Include diabetes prevention, pre-diabetic identification	TBD	Enable use of clinical data to track A1C control & act on data	Mobile apps focus on diabetes management & sharing info with provider
Hypertension (HTN): prevention and control	HTN control (NQF 0018) measure as reporting (short term) and payment (long term) measure *	Standard 2: Health Equity Intervention: diabetes, HTN, or asthma	Foundational PCMH skills	Foundational PCMH skills	Ensure CHW workforce that can identify undiagnosed HTN and do HTN control activities	Recommended: Blood pressure screenings, chronic disease management, anti-hypertensives, ACE inhibitors	Obesity incidence/ prevalence & up-stream indicators	Include HTN prevention, undiagnosed HTN identification	TBD	Enable use of clinical data to track HTN control & act on data	Mobile apps focus on HTN management & sharing HTN info with provider
Asthma	Asthma Hospital/ED admission measure as payment measure *	Standard 2: Health Equity Intervention: diabetes, HTN, or asthma	Foundational PCMH skills	Foundational PCMH skills	Ensure CHW workforce that can do home asthma assessments	Recommended: chronic disease management	(?)	Include asthma triggers assessments	TBD		Mobile apps focus on asthma management & sharing info with provider
Depression	Depression remission & progress (NQF 0710, 1885) as reporting (short term) and payment (long term) measure	Standard 3: Behavioral health integration into primary care, focus on PHQ-9	Depression screening is a new critical element	Promote universal screenings	Enable CHW workforce that can integrate into care teams	Recommended: mental health screenings, anti-depressants	(?)		TBD	Enable use of clinical data to track depression remission control & act on data; enable referral f/u	EHR SaaS enables behavioral health providers to connect to primary care

*In addition to process-oriented claims measures already adopted by most commercial payers and Medicaid (e.g., diabetes eye exam, medication management for people with asthma, etc.)