Connecticut State Innovation Model Driver Diagram

Aims	Primary Drivers	Secondary Drivers
By 6/30/2020 Connecticut will establish: Healthier People While Promoting Health Equity: Reduce statewide rates of diabetes, obesity, and tobacco use Better Care While Promoting Health Equity: Improve performance on key quality measures, increase preventative care and consumer experience, and increase the proportion of providers meeting quality scorecard targets Reduce Healthcare Costs: 1-2% percentage point reduction in annual healthcare spending growth	Promote policy, systems, & environmental changes, while addressing socioeconomic factors that impact health	Engage local and state health, government, and community stakeholders to produce a population health plan
		Identify reliable & valid measures of community health improvement
		Design Health Enhancement Communities (HECs) model that includes financial incentive strategy to reward communities for health improvement
		Design and implement Prevention Service Centers (PSCs)
	Engage consumers in healthy lifestyles, preventive care, chronic illness self- management, and healthcare decisions	Promote the use of Value-Based Insurance Designs (VBID) that Incentivize healthy choices by engaging employers and others
		Provide transparency on cost and quality by creating a public common scorecard to report provider performance, and deploying CAHPs
		Develop informed and actively participating consumers for health reform
		Support data analytics and deploy HIT tools that engage consumers
	Promote payment models that reward improved quality, care experience, health equity and lower cost	All payers in CT use financial incentives to reward improved quality and reduced cost: launch Person Centered Medical Home +(PCMH+)
		Engage payers to increase proportion of CT population with a primary care provider responsible for quality and total cost of care
		Recommend a statewide multi-payer core quality measure set for use in value-based payment models to promote quality measure alignment
		Support data analytics and deploy HIT tools, including a multi-payer solution for the extraction, integration, and reporting of eCQMs
	Strengthen capabilities of Advanced Networks and FHQCs to delivery higher quality, better coordinated, community integrated and more efficient care	Community & Clinical Integration Program (CCIP): Provide technical assistance & awards to PCMH+ participating entities to achieve best- practice standards in: comprehensive care management; health equity improvement; & behavioral health integration
		Advanced Medical Home (AMH) Program: Provide support to primary care practices, within PCMH+ participating entities, that are not medical homes, to become AMHs
		Promote use of Community Health Workers through technical assistance, resource development, and policy recommendations
		Establish a statewide health information exchange
		Coordinate HIT initiatives & execute broad stakeholder engagement
		Establish infrastructure for sending alerts to providers and caregivers

Driver Diagram Drill Down: Primary Driver 1

AIMS
- Healthier People while Promoting Health Equity
- Better Care while Promoting Health Equity
- Reduced Healthcare Costs

Primary Driver 1
Promote policy, systems, & environmental changes, while addressing **socioeconomic factors that impact health**

Secondary Driver	Measure	Accountability Targets			
		PIP	PY1	PY2	PY3
Engage local and state health, government, and community stakeholders to produce a population health plan	Number of multi-stakeholder council meetings held	3	12	12	12
	Number of external stakeholder engagements (including agency discussions, in and out of state interviews, community forums)	10	20	-	-
Identify **reliable & valid measures** of community health improvement	Number of measures reviewed	5	30	-	-
	Number of different SES factors considered in measure recommendation process	-	10	-	-
	Number of community health measures recommended by council	-	5	-	-
	Number of community health measures incorporated into quality scorecards (per payer)			2	-
Design **Health Enhancement Communities (HECs)** model that includes financial incentive strategy to reward communities for health improvement	Number of accountable community models assessed	0	5	-	-
Design and implement **Prevention Service Centers (PSCs)**	Number of prevention models assessed	5	-	-	-
	Number of regions and organizations considered	0	5	-	-
	Number of PSC demonstrations launched	0	0	3	5

Driver Diagram Drill Down: Primary Driver 2

AIMS
- Healthier People while Promoting Health Equity
- Better Care while Promoting Health Equity
- Reduced Healthcare Costs

Primary Driver 2
Engage consumers in healthy lifestyles, preventive care, chronic illness self- management, and healthcare decisions

Secondary Driver	Measure	Accountability Targets			
		PIP	PY1	PY2	PY3
Promote the use of **Value-Based Insurance Designs (VBID)** that Incentivize healthy choices by engaging employers and others	Number of different employers engaged in Learning Collaborative meetings	0	30	30	30
	Number of Learning Collaborative meetings or events (webinars, etc.)	0	10	10	10
	Number of self-insured employers adopting VBID	0	30	60	90
	Number of fully-insured employers adopting VBID	0	0	60	120
	% of Commercially Insured Population in a VBID plan that aligns with CT SIM's VBID threshold	44%	53%	65%	75%
Provide transparency on cost and quality by creating a public **common scorecard** to report provider performance, and deploying CAHPs	Number of valid measures recommended for public reporting	50	50	60	70
	Number of quality measures regarding performance of CT's ANs and FQHCs publically reported		30	35	50
	Number of views to public scorecard	-	0	3,000	4,000
	Number of organizations/entities that have self-attested to using data from scorecard	-	-	20	40
	% health plans that use CAHPS in their scorecards ties to payment	-	-	50%	50%
Develop informed and actively participating consumers for health reform	Number of consumers involved in SIM governance (SIM HISC, CAB and identified committees)	50	50	50	50
	New consumers in consumer-related SIM roles	-	5	5	5
	Number of issue-driven meetings (including in-person, focus groups, forums, webinars, etc.)	5	TBD	TBD	TBD
	Number of consumers engaged through events	TBD	TBD	TBD	TBD
	Number of trainings held	TBD	TBD	TBD	TBD
	Social media metric (e.g., followers, utility of info)	TBD	TBD	TBD	TBD
	Number of consumer-driven documents developed	TBD	TBD	TBD	TBD
Support **data analytics** and deploy **HIT tools** that engage consumers	Number of mobile application projects deployed	0	0	2	-
	Number of beneficiaries using mobile applications	0	0	1000	2000
	Advanced Networks or FQHCs using e-consult	0	0	2	4

Driver Diagram Drill Down: Primary Driver 3

AIMS
- Healthier People while Promoting Health Equity
- Better Care while Promoting Health Equity
- Reduced Healthcare Costs

Primary Driver 3
Promote payment models that reward improved quality, care experience, health equity and lower cost

Secondary Driver	Measure	Accountability Targets			
		PIP	PY1	PY2	PY3
All payers in CT use financial incentives to reward improved quality and reduced cost: launch **Person Centered Medical Home +**(PCMH+)	Number of beneficiaries in PCMH+	0	215,000	429,000	439,000
	Number of Advanced Networks in PCMH+	0	3	12	12
	Number of FQHCs in PCMH+	0	9	14	14
	Number of PCPs in PCMH+	0	516	1,624	1,624
Engage payers to increase proportion of CT population with a primary care provider responsible for quality and total cost of care	Number of beneficiaries in any SSP	1,099,882	1,745,012	2,270,404	2,595,792
	Number of PCP participation in any SSP	-	4,693	5,072	5,450
Recommend a statewide multi-payer **core quality measure set** for use in value-based payment models to promote quality measure alignment	% alignment across health plans on core quality measure set (commercial/Medicaid)	-	55%	65%	75%
	% alignment across health plans on core quality measure set (commercial)	-	59%	67%	75%
Support **data analytics** and deploy **HIT tools**, including a multi-payer solution for the extraction, integration, and reporting of eCQMs	Average number of eCQMS used in value-based scorecards (for reporting or payment) across health plans in Connecticut	0	0	3	5

Driver Diagram Drill Down: Primary Driver 4

AIMS
- Healthier People while Promoting Health Equity
- Better Care while Promoting Health Equity
- Reduced Healthcare Costs

Primary Driver 4
Strengthen capabilities of Advanced Networks and FHQCs to delivery higher quality, better coordinated, community integrated and more efficient care

Secondary Driver	Measure	Accountability Targets			
		PIP	PY1	PY2	PY3
Community & Clinical Integration Program (CCIP): Provide technical assistance & awards to PCMH+ participating entities to achieve best-practice standards in: comprehensive care management; health equity improvement; & behavioral health integration	Number of Advanced Networks participating in CCIP	-	3	12	12
	Number of FQHCs Networks participating in CCIP	-	1	1	1
	Number of participating providers	-	356	1,364	1,364
	Number of Transformation Awards awarded	-	4	9	0
	Number of ANs/FQHCs that have met core standards	-	0	4	9
Advanced Medical Home Program: Provide support to primary care practices, within PCMH+ participating entities, that are not medical homes, to become AMHs	Number of new practices that enroll in the AMH program	0	150	150	0
	Number of practices that complete AMH program			135	270
	Number of practices obtaining AMH designation	0	0	120	240
Promote use of Community Health Workers through technical assistance, resource development, and policy recommendations	Number of training programs inventoried	-	25	25	-
	Number of group CHW TA sessions (May be adjusted once CCIP vendors on board)	-	5	10	5
	Number of CCIP Employer TA sessions	-	15	15	5
	Number of CHW certifications issued	-	-	25	50
	Number of CHW resources website visits	-	-	100	150
	% of Advanced Networks and FQHCs that have CHWs integrated into care teams (non-grant funded)	TBD	TBD	TBD	TBD
Establish a statewide **health information exchange**	TBD	TBD	TBD	TBD	TBD
Coordinate HIT initiatives & execute broad stakeholder engagement	TBD	TBD	TBD	TBD	TBD
Establish infrastructure for sending **alerts** to providers and caregivers	TBD	TBD	TBD	TBD	TBD