Connecticut SIM Logic Model: Legend

Categories

1. Inputs: A set of defined resources that will enable the activities to be accomplished
2. Activities: Defined set of activities conducted to address the health care issues
3. Outputs: Evidence produced from the completed activities
4. Outcomes: Defined measures/changes that will occur within the four year grant from the completed activities
5. Impacts: Overall, statewide changes that will occur as a result of completing the activities

Terminology

Initiatives

1. AMH: Advanced Medical Home
2. CCIP: Community and Clinical Integration Program
3. MQISSP: Medicaid Quality Improvement and Shared Savings Program
4. VBID: Value-Based Insurance Design
5. VBP: Value-Based Payment

Other

1. AN: Advanced Networks
2. BH: Behavioral Health
3. CCT: Comprehensive Care Team
4. CHW: Community Health Worker
5. FQHCs: Federally Qualified Health Centers
6. HEC: Health Enhancement Community
7. MH: Medical Home
8. PSC: Prevention Service Center
9. TA: Technical Assistance

Connecticut SIM Logic Model: Detailed Information (1/4)

Inputs → **Activities** → **Outputs** → **Outcomes/Impact**

Inputs

SIM Grant Funds

Multi Stakeholder Workgroups: HISC, PTTF, QC, EAC, HIT, PHC, MAPOC, Employer Consortium, Rapid Response Team, Consumer Advisory Board

Stakeholder Engagement: Employers, Consumers, Providers, Health plans, Government

Regulatory Levers

HIT: Direct messaging, Provider Directory, ADT, edge server, eMPI, consent registry, disease registries

Consumer Engagement: Focus groups, listening sessions, forums

Activities

I. Improve Health Care Quality

ANs / FQHCs

A. Value-based Payment (VBP)

1. Increase adoption of value-based payment through payer and provider engagement and MQISSP
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, mammograms, well-child visits)
   b. chronic care services (diabetes, asthma, hypertension)
   c. behavioral health services (depression screening, depression remission, ADHD management);
   d. effective management of individuals with complex care needs (ED use, readmissions)
3. Deploy health information technology solution that can support the extraction of clinical data to allow payer adoption of clinical measures for value-based payment

B. Community and Clinical Integration Program (CCIP)

1. Provide TA/awards to MQISSIP participants to achieve standards in **comprehensive care management** , including:
   a.1 Networks having the capability to identify complex patients through risk stratification that considers clinical, behavioral, and social risk factors
   a.2 Process for connecting patients to a comprehensive care team (CCT) (w/ Community Health Worker) to receive more intensive care management support (Work flow still needed to be defined, may need technology solution)
   a.3 CHW performing care coordination and linking individuals with social service
   b.1 Root cause analysis and a person-centered needs assessment to identify and implement additional interventions
   b.2 Developing person-centered care coordination plan
   c. Modifying process for exchanging health info. across care settings to accommodate function of CCT
   d. On-going monitoring of patient condition
   e. Evaluating the model: tracking aggregate measures; method to share performance data with CCT
2. Provide TA/awards to MQISSIP participating entities to achieve standards in **behavioral health integration**, including:
   a.1 Providers having capability to utilize screening tool for mental health, substance abuse, and trauma needs (in PC setting)
   a.2 Assessment of needed behavioral health resources and mechanism for identifying resources
   a. 3 Collaborating with BH providers and patient through mutual agreement and develop processes and protocols (referral tracking, follow-up, etc.)
   a.4 MOU w/behavioral health provider (guidelines on information sharing; tech. to alert PCP referral complete)
   a.5 Ongoing training for PCP around BH (promotion, detection, diagnosis, referral)
   a.6 Protocol and tech solutions to make assessment and care plan available to PC team with consent

Outputs

A.1 MQISSP: 400,000+ lives by 2019

A.2 Payers better aligned on core quality measures used in VBP
   a. preventative services: Breast Cancer, Cervical Cancer, and Colorectal Cancer Screening, Well Child Visits in first 15 months of life, Adolescent well care visits, Wgt. assessment and counseling for nutrition and physical activity for children/adolescents
   b. chronic care services: Medication management for people w/ asthma, Asthma Medication Ratio, DM: Hemoglobin A1c Poor Control (>9%), DM: HbA1c Testing, DM: Diabetes eye exam, DM: medical attention for nephropathy, Controlling high blood pressure
   c. behavioral health services: Follow-up care for children prescribed ADHD medication, Metabolic Monitoring for Children and Adolescents on Antipsychotics, Depression Remission at 12 Twelve Months, Child & Adolescent Major Depressive Disorder: Suicide Risk Assessment, Unhealthy Alcohol Use – Screening
   d. effective management: Plan all-cause readmission, ED usage per 1,000

A.3 Payers accurately collect clinical data from provider EHRs in automated way

B.1 30 ANs/FQHCs succeed in CCIP standards by 2019 demonstrating improved management of individuals with complex health needs and have analytic tools to better predict who requires care management
   a.1-3 Providers can identify complex individuals who will benefit from the support of a CCT
   b.1-2 Ability to understand the historical and current clinical and social needs of individuals
   c. Providers receive timely alerts for hospital related care events even when the hospital is not in network
   d. Providers have efficient process for managing consent, easing communication with care partners, efficient & effective health information sharing across the health neighborhood
   e. Patients have a better care experience, feel more engaged, and better adhere to treatment which is tuned to values, preferences, and goals
   f. Providers use disease registries and evidence based decision support to address gaps in care

B.2 30 ANs/FQHCs demonstrate improved identification of BH conditions with effective treatment, referral and/or follow-up
   a.1-6 Providers have improved ability to identify and treat BH needs

Outcomes/Impact

Process/ Structural Outcomes

- 88% of Medicaid beneficiaries in VBP by 2020
- Commercial payers **xx%** of members in VBP by 2020
- 88% of CT population goes to PCP responsible for the quality and cost of their care by 2020

Quality of Care Impact

- Increase in **colorectal screening** for adults 50+ from 75.7% to 83.6%; Increase in colorectal screening for low income adults from 64.9% to 68.2%
- Increase in **mammograms** for women ages 50+ in last two years from 83.9% to 87.7%
- Increase optimal **diabetes care** – as measured by 2+ annual A1c tests from 72.9% to 80.1%; Increase in adults with **hypertension** who take hypertension medication from 60.1% to 69.5%
- Reduction in **ED use** with asthma as the primary diagnosis from 73 to 64 per 10,000
- Reduction in number of **mental health days**
- Reduction of risk-standardized all-condition readmissions from 15.9% to 13.1%
- Reduction in **ambulatory care sensitive condition admissions** to 1,449 to 1,195 per 100,000
- Increase in **adults who have a regular source of care** from 83.9% to 93.0%
- Increase in **children well child visits** for at-risk pop. from 62.8% to 69.1%
- Decrease in **premature death rates** for adults due to cardiovascular disease to 889 to 540 per 100,000

Health Care Sustainably Impact

- 1-2% percentage point reduction in annual healthcare spending growth, by 2020

Connecticut SIM Logic Model: Detailed Information (2/4)

Inputs	Activities	Outputs	Outcomes/Impact

SIM Grant Funds

Multi Stakeholder Workgroups: HISC, PTTF, QC, EAC, HIT, PHC, MAPOC, Employer Consortium, Rapid Response Team, Consumer Advisory Board

Stakeholder Engagement: Employers, Consumers, Providers, Health plans, Government

Regulatory Levers

HIT: Direct messaging, Provider Directory, ADT, edge server, eMPI, consent registry, disease registries

Consumer Engagement: Focus groups, listening sessions, forums

I. Improve Health Care Quality

ANs / FQHCs

C. Advanced Medical Home (AMH)

1. Provide TA to non-MH practices in MQISSIP participating Advanced Networks to achieve standards in Patient-Centered Access, Team-based Care, Population Health Management (e.g., Mental health/ substance use history of patient and family, standardized tool for developmental screening), Care Management and Support, Care Coordination and Care Transitions (e.g., proactively identifying patients with unplanned hospital admissions and emergency department visits), Performance Measurement and Quality Improvement
2. Pilot program (AMH Vanguard) with 50 practices who receive state funded practice transformation support for up to 15 months
3. Provide support to non-MH practices to achieve Planetree Patient-Centered Bronze Recognition for excellence in patient-centered care
4. Participants take part in Learning Collaborative conducted by Qualdigm consisting of in-person meetings, virtual group education meetings, and technical assistance

C.1 Care is more person-centered, team-based, preventative, evidence-based, population health oriented, coordinated, and effective
C.1 Improved practice and patient experience
C.2 Pilot sites receive NCQA Level 2 or Level 3 Patient-Centered Medical Home recognition
C.3 Participating PCPs meet the required criteria to fulfil Planetree Bronze Recognition for Achievement in Patient-Centered Care
C.4 PCPs move toward person-centered care through changes in leadership approach, culture and systems and maximizing the sharing among practices of resources, tools, and strategies for practice transformation.

Employers

D. Value-based Insurance Design (VBID)

1. Engage employers to adopt VBID health plans that reward use of disease management & treatment support services, high performing providers who adhere to evidence-based treatment, high value treatment services

D.1 Employers adopt value based insurance designs
D.1 Consumers empowered to make healthier lifestyle decisions and engage in illness self-management

Process/ Structural Outcomes

- 300+ practices are AMH by 2019
- 87% of insured population in VBID by 2020

Quality of Care Impact

- Increase in **colorectal screening** for adults 50+ from 75.7% to 83.6%; Increase in colorectal screening for low income adults from 64.9% to 68.2%
- Increase in **mammograms** for women ages 50+ in last two years from 83.9% to 87.7%
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- Increase in **adults who have a regular source of care** from 83.9% to 93.0%
- Increase in **children well child visits** for at-risk pop. from 62.8% to 69.1%
- Decrease in **premature death rates** for adults due to cardiovascular disease to 889 to 540 per 100,000

Health Care Sustainably Impact

- 1-2% percentage point reduction in annual healthcare spending growth, by 2020

Connecticut SIM Logic Model: Detailed Information (3/4)

Inputs	Activities	Outputs	Outcomes/Impact
SIM Grant Funds **Multi Stakeholder Workgroups:** HISC, PTTF, QC, EAC, HIT, PHC, MAPOC, Employer Consortium, Rapid Response Team, Consumer Advisory Board **Stakeholder Engagement:** Employers, Consumers, Providers, Health plans, Government **Regulatory Levers** **HIT:** Direct messaging, Provider Directory, ADT, edge server, eMPI, consent registry, disease registries **Consumer Engagement:** Focus groups, listening sessions, forums	**II. Reduce Health Disparities** **A. Value-based Payment (VBP)** 1. Promote alignment among payers on core quality measure set that reward improvement in health equity: a. chronic care (diabetes, asthma, hypertension) b. effective management of individuals with complex care needs (ED use, readmissions)	A.1 Payers better aligned on core quality measures focused on health equity improvement a. chronic care: Medication management for people w/ asthma, Asthma Medication Ratio, DM: Hemoglobin A1c Poor Control (>9%), DM: HbA1c Testing, DM: Diabetes eye exam, DM: medical attention for nephropathy, Controlling high blood pressure b. effective management: effective management: Plan all-cause readmission, ED usage per 1,000	Process/ Structural Outcomes • 88% of CT population goes to PCP responsible for the quality and cost of their care by 2020 • 300+ practices are AMH by 2019 Quality of Care Impact Improved core dashboard measures for equity gaps in target selected areas: ➢ **Diabetes**: Reduce disparities in rates of A1c Poor Control ➢ **Asthma**: Reduce disparities in asthma medication ratio ➢ **Hypertension**: Reduce disparities in controlling blood pressure ➢ **Consumer Experience**: Reduce disparities in consumer experience survey results Health Care Sustainably Impact • 1-2% percentage point reduction in annual healthcare spending growth, by 2020
	B. Community and Clinical Integration Program (CCIP) 1. Provide TA/awards to MQISSIP participating entities to achieve standards in **health equity improvement**, including: a.1 Networks have the capability to analyze select clinical performance and care experience measures stratified by race/ethnicity, language, etc. a.2 Networks have tool to conduct risk stratification that takes into consideration utilization, health outcomes and social determinants of health a.3 Networks have tool to track aggregate clinical outcome and care experience measures aligned with disparity measures a.4 Networks have tool to identify valid clinical and care experience measures to compare performance between sub populations b. Designing one culturally & linguistically appropriate chronic illness to address gaps, which incorporates a CHW c. Developing processes and protocols for connecting individuals to needed community services	B.1 30 ANs/FQHCs succeed in CCIP standards by 2018 demonstrating standardized processes in health equity improvement and have analytic tools to better compare different populations a.1-4 Networks will be able to identify disparities in care on a routine basis, prioritize the opportunities for reducing the identified disparities, design and implement interventions, scale those interventions across networks, and evaluate the effectiveness of the intervention a.1-4 Reduction in health equity gaps through standardizing certain elements of the care processes to be more culturally and linguistically appropriate b. Health systems integrate CHWs c. Efficient & effective health information sharing across the health neighborhood exists	
	C. Advanced Medical Home (AMH) 1. Provide TA to non-MH practices in MQISSIP participating Advanced Networks to achieve standards in cultural &linguistic appropriate services, assessment of health literacy, health equity oriented quality improvement	C.1 Care is more centered on achieve best-practice standards in health equity improvement	

ANs / FQHCs

Connecticut SIM Logic Model: Detailed Information (4/4)

Inputs → **Activities** → **Outputs** → **Outcomes/Impact**

SIM Grant Funds

Multi Stakeholder Workgroups: HISC, PTTF, QC, EAC, HIT, PHC, MAPOC, Employer Consortium, Rapid Response Team, Consumer Advisory Board

Stakeholder Engagement: Employers, Consumers, Providers, Health plans, Government

Regulatory Levers

HIT: Direct messaging, Provider Directory, ADT, edge server, eMPI, consent registry, disease registries

Consumer Engagement: Focus groups, listening sessions, forums

III. Improve Population Health

ANs / FQHCs

A. Value-based Payment (VBP)

1. Promote alignment among payers on core quality measure set that rewards improvement in:
   a. preventive care processes (tobacco cessation, weight assessment and counseling, cancer screening, well visits)
2. Establish and implement reliable & valid measures of community health improvement
3. Deploy health information technology solution that can support the extraction of clinical data to allow payer adoption of clinically-based measures for value-based payment

A.1 Payers better aligned on core quality measures used in VBP
   a. preventative services: Breast Cancer, Cervical Cancer Screening, Colorectal Cancer Screening, Well Child Visits in first 15 months of life, Adolescent Well care visits, Wgt. assessment and counseling for nutrition and physical activity for children/adolescents
A.2 Improved population health in areas in areas of focus
A.3 Payers accurately collect clinical data from provider EHRs in automated way

B. Advanced Medical Home (AMH)

1. Provide TA to non-MH practices in MQISSIP participating Advanced Networks to achieve standards related to population health management

B.1 Care is more centered on achieving best-practice standards in population health management

Community

C. Population Health Plan Design and Implementation

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

C.1 2-3 PSCs offering evidence-based community preventive services are designated
C.2 1-2 HECs are designed and designated
C.3 Networks have ability to understand the historical and current clinical and social needs of individuals for preventative services
C.4 Early buy-in, successful program design, and establishment of long-term support
C.5 Communities track and are accountable for community health measures *(Date TBD)*
C.6 Comprehensive financial model for HEC developed by Q2 2017

Employers

D. Value-based Insurance Design (VBID)

1. Engage employers to adopt VBID health plans that reward healthy lifestyles (e.g., physical activity) targeted towards reducing rates of diabetes, obesity, tobacco use, hypertension, etc. and use of high value preventative services

D.1 Employers adopt value based insurance designs
D.1 Consumers empowered to make healthier lifestyle decisions and engage in illness self-management

Process/ Structural Outcomes

- 88% of Medicaid beneficiaries in VBP by 2020
- Commercial payers **xx%** of members in VBP by 2020
- 88% of CT population goes to PCP responsible for the quality and cost of their care by 2020
- 300+ practices are AMH by 2019
- 87% of insured population in VBID by 2020
- 2-3 PSCs offering evidence-based community preventive services in affiliation with providers exist in the state by Q1 2018
- 1-2 HECs exist in the state by Q1 2019

Population Health Measures Impact

- Reduction in percent of **obese** adults from 24.5% to 22.95% and percent of obese children from 18.8% to 17.65%
- Reduction in percent of **obese children** in low income households from 38% to 35.55%
- Reduction in percent of **adults who smoke** to 14.40% and youth who smoke from 14% to 12.72%
- Reduction in percent **of low income adults who smoke** from 25% to 22.43%
- Reduction in **adult diabetes** to 7.86%
- Reduction in low income adults with diabetes from 14.3% to 11.32%

Health Care Sustainably Impact

- 1-2% percentage point reduction in annual healthcare spending growth, by 2020

Cost Goals PMPM	Baseline	2020 Goal
ASO/Fully Insured	$457	$603
State employees w/o Medicare	$547	$722
Medicare	$850	$1,096
Medicaid/CHIP, incl. expansion	$390	$509
Average	$515	$679