

# SIM TEST GRANT LOGIC MODEL

**State Healthcare Innovation Plan Vision:** Establish a whole-person-centered health care system that improves community health and eliminates health inequities; ensures superior access, quality, and care experience; empowers individuals to actively participate in their health and healthcare; and improves affordability by reducing healthcare costs.

Inputs	Model Test Activities	Outputs	Measureable Outcomes	Financial Impact
<ul style="list-style-type: none"> <li>• AMH Standards</li> <li>• Payer alignment on core performance metrics / common scorecard, reimbursement methods for non-visit care, APM, VBP methods including care experience.</li> <li>• Multi Stakeholder Workgroups: Practice Transformation, Quality, Equity and Access</li> <li>• Stakeholder Engagement: Employers, Consumers, Providers, Healthplans</li> <li>• Employer VBID acceleration</li> <li>• Practice Transformation Vendor</li> <li>• Workforce Survey</li> <li>• <b>HIT:</b> <u>State-level/Shared Utility:</u> HIE, Direct Messaging, Provider Directory, Workforce Database, Disease Registries. <u>Practice-level:</u> ONC-certified EHR, eRx, Secure Email, high risk alerts, shared decision making tools, e-consults, care management tools, telehealth</li> <li>• <b>Analytics:</b> <u>State level:</u> APCD, Workforce Database, cross-payer cost, quality, and care experience analytics; program evaluation; <u>Practice level:</u> population health, risk stratification, CQI reporting</li> <li>• Primary care workforce development: CT Service Track, Community Health Worker Training &amp; Certification, Teaching Health Centers</li> <li>• Regulatory levers</li> </ul>	<p><b>CARE DELIVERY</b>  <u>Small-Mid size Practices (~20%/500)</u></p> <ul style="list-style-type: none"> <li>• Recruit primary care practices to AMH model</li> <li>• Establish transformation support services</li> <li>• Establish credentialing mechanism</li> </ul> <p><u>Large Practices/ACOs (~80%/2,000)</u></p> <ul style="list-style-type: none"> <li>• Learning collaboratives to enable success</li> <li>• Innovation Awards: Clinical and Community Integration</li> </ul> <p><b>PAYMENT REFORM</b></p> <ul style="list-style-type: none"> <li>• Geo-pooling unaffiliated practices for AMH/SSP</li> <li>• SSP tied to common performance scorecard</li> <li>• SSP tied to care experience</li> <li>• Advance payments for non-visit care</li> <li>• Advance payments for care coordination</li> </ul> <p><b>POPULATION HEALTH PLAN</b></p> <ul style="list-style-type: none"> <li>• Integration of pop health – care delivery</li> <li>• Features: diabetes, asthma, tobacco use, obesity, falls</li> <li>• Health Enhancement Communities</li> <li>• Health Equity</li> </ul>	<p><b>Enhanced primary care practice capabilities</b></p> <ul style="list-style-type: none"> <li>• Whole-person-centered care</li> <li>• Enhanced access</li> <li>• Team based coordinated and non-visit primary care</li> <li>• Population health management</li> <li>• Integration of clinical and community resources</li> <li>• Community based shared utility – CHWs, Prevention Services</li> <li>• Culturally and linguistically appropriate care</li> <li>• Evidence based informed decision making</li> <li>• Meaningful use – EHR</li> </ul> <p><b>Empowered Consumers</b>            Before office visit (e.g. transparency - provider performance, quality, &amp; cost), during office visit (e.g. shared decision making, eRx), instead of office visit (e.g. econsults, telehealth), and after office visit (e.g. EHR portal for lab results, referrals; care experience survey)</p> <p><b>Reduced costs</b></p> <ul style="list-style-type: none"> <li>• Migration away from FFS toward value based payment</li> <li>• Inclusion of unaffiliated practices in value based payment</li> <li>• Incentivized coordination of primary care with Prevention Services, CHWs, and Specialists</li> <li>• Incentivized delivery of preventative care for obesity, tobacco use, falls; and chronic condition management for asthma, diabetes</li> </ul> <p><b>Improved quality of care</b>            Common scorecard measures, including diabetes, obesity, tobacco use, asthma, and falls.</p> <p><b>Improved care experience</b> for measures published on common care experience survey</p> <p><b>Adequate primary care workforce</b> through increased training of primary care providers and community health workers in alignment with workforce analytics</p>	<p><b>Practice Transformation</b></p> <ul style="list-style-type: none"> <li>• %/# practices/patients attributed to AMH model</li> <li>• %/# practices/patients reimbursed via FFS alternatives</li> </ul> <p><b>Better Health</b>            Decrease the statewide rates of diabetes, obesity, tobacco use, asthma, and falls</p> <p><b>Quality of Care &amp; Care Experience</b></p> <ul style="list-style-type: none"> <li>• % of providers meeting quality scorecard targets</li> <li>• Achieve top-quintile performance among all states for key measures of quality of care, increased preventative care, consumer experience</li> </ul> <p><b>Health Equity</b></p> <ul style="list-style-type: none"> <li>• Close the gap between the highest and lowest achieving populations for each target measure</li> </ul> <p><b>Resource Efficiency</b></p> <ul style="list-style-type: none"> <li>• % Reduction in ED visits for ACSCs</li> <li>• % Reduction in hospitalizations for ACSCs</li> <li>• Achieve a rate of healthcare expenditure growth no greater than the increase in gross state product (GSP) per capita, which corresponds to a 1-2% reduction in the annual rate of healthcare growth</li> </ul>	<p>Commercial:            Medicaid:            Medicare:</p>

**SIM Vision:** *to establish a whole-person-centered health care system that improves community health and eliminates health inequities; ensures superior access, quality, and care experience; empowers individuals to actively participate in their health and healthcare; and improves affordability by reducing healthcare costs.*

**SIM Principles:** *to achieve our vision, innovation efforts will be logically integrated and our program decisions will be consistently aligned with a core set of guiding principles.*

- Whole-person-centered care is more than the integration of medical, oral, and behavioral health. It is also the consideration of social, cultural, emotional, and economic contexts for wellbeing. It is team based, coordinated care for individuals with complex needs, and provided in the right setting at the right time.
- A healthy community is a strong community. Community health improvement requires attention to a community's particular healthcare needs and social determinants of health, requires the collaboration of a wide range of community partners, and the expansion of a diverse and well-trained workforce that includes "non-traditional" providers such as community health workers.
- Every person has the right to be treated with respect, to receive culturally and linguistically appropriate whole-person-centered care, and to be fully informed and share in decisions that affect them and their families, regardless of socioeconomic status, race, ethnicity, language, gender/transgender, sexual orientation, geography, religion, ability/disability, or age.
- Health information technology powers primary care transformation, enabling point of care information and communications, continuous learning, and performance improvement. The use of technology for data collection and analytics provides for evidence-based approaches to care delivery, population health management, consumer access to cost and quality information, and tools to measure achievement of access, quality, equity, and cost goals.
- Healthcare economics must change so that providers are financially rewarded for whole-person-centered and evidence-based care, the continuous improvement of quality and care experience, and the reduction of unnecessary and avoidable costs, to improve affordability.
- Access to information that is culturally and linguistically appropriate is vital for improved health literacy to empower all patients to navigate the healthcare system, to choose their providers, to actively participate in their health and healthcare decisions, and to play an active role in their community and statewide health policy.
- Quality primary care is the bedrock of an effective healthcare delivery system. Access to primary care that is whole-person-centered, safe, effective, equitable, and based on the strongest clinical evidence is both fundamental and essential for improving health and healthcare outcomes.
- A highly-trained, well-equipped, and diverse primary care workforce with the capacity to meet the evolving needs of our population's health and the demands of healthcare system reforms is crucial to the attainment of our vision.
- Affordability of healthcare will not be achieved at the expense of quality healthcare. We will not reward the achievement of cost savings through inappropriate means, including under-service of patients.
- For our healthcare delivery system transformation to be meaningful and sustainable, we must continuously engage our stakeholders, including consumers, advocates, employers, community organizations, providers, local and state officials, Medicaid, Medicare, and private health plans.
- The advancement of our vision requires a commitment to measuring the impact of transformation initiatives on health, access, quality, equity, and costs, and further, by establishing a mechanism for oversight and mid-course corrections.