CTC DRAFT LOGIC MODEL FOR IMPACT

Practices | **Population/Community Health** | **Health Systems** | **Cross Cutting**

INPUTS	STRATEGIES	OUTPUTS (1 YEAR)	SHORT TERM OUTCOMES (2-3 YEARS)	IMPACT (5 Years)
Diversified Board of Directors and staff/consultant team (race/ethnicity and sector)	Strengthen Team Based Care (IBH, Pharmacy, NCM, MA, CHWs, etc.) and Improve Workforce Well Being	Establish statewide IBH training capacity for BH clinicians	Behavioral health care is integrated into every primary care practice • % of practices with IBH • Clinical outcomes of integrated IBH • Cost outcomes of integrated IBH	Health care delivery is fully coordinated across all care systems (health and social)
Strong relationships with ACOs, AEs, state agencies, payers, and practices	Learning in action collaboratives	Support practice team learning in action collaboratives focused on evidence based practices in chronic disease management on priority diagnoses	Practices are redesigned to support new payment models and enhance capacity • TBD	Primary care practices (pediatrics and adults) are thriving in an all-payer value-based payment model that stabilizes health care costs and premiums
Access to evidence based practices (learning) and networks (distribution)	Continued IBH in Pediatric and Adult Practices	# of pilots created • health equity • patient engagement • value based payment	Practices are supported in addressing workforce well-being and development • TBD	All Rhode Islanders have access to primary care, practices that reflect the demographics of their community, and are highly satisfied with their care experiences
Consistent and stable funding to invest in long term system transformation strategies	Strengthen community-clinical linkages (e.g., R to E, CHWs/CHTs, Family Visiting)	Create learning in action opportunities on moving to value-based payment models, patient engagement, and health equity.	Increased Coordination with Community Based Organizations • CHW metrics • Rhode to Equity metrics • HEZ and Family Home Visiting metrics • Other?	Primary care providers and their teams are well supported and resourced (financial, human, technology, data, other) to deliver high-quality care
Shared and Agreed Upon Design Principles • Multi payer • Collaborative learning across systems of care • Spread within system of care • Best practices and EVPs • All practices invited	Strengthen Health System Communication, Coordination and Alignment • Pediatric to adult • Behavioral health and health • Specialists and primary care • RI Moms PRN • CHTs	# of individuals that participate and complete CTC training programs (list out what they are)	Improved clinical outcomes for preventive, chronic, and complex care	Rhode Island population health results for kids, adults, and seniors are among the best in the nation, and health disparities are eliminated
Accepted Standards and Measures (OHIC and AE)	Convene key partners to create a shared data framework to track and monitor our work and progress in key areas of equity, patient engagement, workforce wellbeing, and access	Program evaluation results for population health initiatives (includes CHWs)	Improved Transitions of Care • Pediatric to adult transition metrics • Behavioral health transition metrics	
		Successful implementation of phase one eConsult and Enhanced Referral Program with Integra and Lifespan	Successful expansion of eConsult and Enhanced Referral Program to additional specialties and PCPs in all Systems of Care	
		Statewide agreement on PCP/Specialist referral expectations		
	Embed Risk Stratification and an Equity Lens in all Learning Collaboratives	Create a dashboard of primary care population health indicators (including equity, patient engagement, workforce well being, and access measures)	Reduced Health Disparities • Commonwealth Fund Report Card results • Health equity challenge results	

SUNSETTING WORK: PCMH Kids, SBIRT, Telehealth