Cross Cutting Drivers

Quality Measurement	Health IT Enhancement	Roadmap to Improve Population Health
Align Clinical & Claims-Based Measures Linked to Payment By:		
Selecting measures that represent quality and motivate providers to improve outcomes	Developing the infrastructure needed to collect and report the clinical and claims based measures	Selecting measures that represent population health strategies that support population health improvement
Increase ACO Models with Up & Down Side Risk By:		
Incorporating quality measures the appropriately tie to payment structure	Developing the infrastructure needed to collect and report the clinical and claims based measures	Introducing payments at risk, linked to quality in the community C3 setting
Mature Infrastructure and Use of HIT Analytics to Support VBP By:		
Continuing to work with stakeholders to refine quality measures, risk adjustment methodology, and attribution to produce a transparent and fair quality score linked to payment	Mature the use of existing IHIN resources to effectively move health data; Identify and build HIT infrastructure where needed	Encourage the use of SWAN and the IHIN in C3 communities to improve care coordination during clinical transitions and to close referral loops (both clinical and social referrals)
Elevate the use of SDH Data within VBP Programs By:		
Identifying key SDH questions that are standardized and collected statewide. Once established, the state will work on linking those results to payment through ACO contracting	Identifying tools and processes to collect and analyze the data statewide	Utilize community-based care coordinators to provide community-clinical linkages to social services and supports.
Implement Accountable Communities of Health Pilot to Prepare Communities for Value-based Delivery Models By:		
Working with communities to use quality measures to improve local workflow (scorecards), including measures linked to VBP	Providing technical assistance to communities working on close loop referrals for social care coordination activities	Establishing requirements to implement SW Strategy Plans that cover clinical, innovative patient-centered care, & community-wide health.
Address Patient Social Needs Through Linkages to Community Based Resources		
Measuring SDH needs at a community level through referrals, and patient screenings (HRAs) allows communities to access policy level gaps and make improvements that focus on population health needs	Building system resources at a community level to track social need referrals and ensure that each referral loop is closed	Aggregating social needs at a state, local and clinic level provides data that informs policies that promote population health strategies
Utilize the IHIN and SWAN to Optimize Transitions of Care By:		
Using the IHIN and SWAN, ACO providers can monitor improvements in quality measures linked to VBP contracts.	Establishing processes to embed IHIN and SWAN use cases into clinical practice flows.	Encourage the use of SWAN and the IHIN in C3 communities to improve care coordination during clinical transitions and to close referral loops (both clinical and social referrals)
Develop a Community Scorecard for Process Improvement that Emphasizes & Raises the Standards of Care By:		
Working with communities to use quality measures on community level score cards to improve local workflow	Establishing data sharing protocols at a local level to collect clinical data from multiple sources and compute the data into a community level scorecard	Using measures in the scorecard that focus on Statewide Strategy Plans to cover clinical, innovative patient-centered care, and community-wide health.
Improve the Use of HRAs that Collect SDH & Measure Health Confidence By:		
Establishing a path to collect standardized SDH and Patient Confident data that can be linked made into a quality measure linked to payment	Using technology (secure online tools, patient and provider portals, etc.)to share patient reported health data with clinicians	Using HRAs to improve care coordination for social need services for the Population Health Roadmap target population
Provide Technical Assistance to Providers Engaged in Transformation & Value-Based Models By:		
Equipping ACO providers to measure quality that drives better health outcomes.	Equip providers and communities to use HIT tools (SWAN/ IHIN) to improve outcomes and increase success in value-driven contracting	Equipping communities to carry out C3 ACH work plans that focus on Statewide Strategy Plans and social care needs for the target population