Updated Driver Diagram

Table 1: Driver Diagram

This is our Rhode Island Driver Diagram, laying out our Aims, Primary and Secondary Drivers, Interventions, and associated Metrics.

Vision
IMPROVE THE HEALTH OF RHODE ISLANDERS Create measurable improvements in Rhode Islander's physical and mental health. Targeted measures include, but are not limited to, rates of diabetes, obesity, tobacco use and depression.

AIM	PRIMARY DRIVER	SECONDARY DRIVER	INTERVENTIONS	METRIC(S)	TARGET(S)
1. REDUCE RATE OF INCREASE IN RHODE ISLAND HEALTHCARE SPENDING Move to a "value-based" health care system that pays health care providers for delivering measurable high quality health care, rather than paying providers for the volume of procedures, office visits, and other required services that they deliver.	Change our payment system (all-payer) to 80% value-based by 2018, with 50% of payments in alternative payment methodologies	Using regulatory and purchasing/contracting levers at OHIC and Medicaid, implement rules and conditions that expand value-based payment more broadly across the commercial and Medicaid markets	Continue to implement OHIC's Affordability Standards and Medicaid's Accountable Entities; ensure their alignment and integration with other state and private VBP activities	Percentage of payments made under an APM.	50%
				Percentage of payments linked to value.	80%
		Aligning quality measures for healthcare contracting	Create an ongoing governance structure to implement the aligned measure sets (primary care, ACO, hospital, behavioral health, and maternity) and update metrics as needed	Percentage of insurers/payers adopting the SIM aligned measure sets into their contracts with providers	100%
		Enhance and/or create programs to address needs of high utilizers coordinated across payers	Support integrated Community Health Teams and Screening, Brief Intervention, and Referral to Treatment (SBIRT) in our unified project	See CHT metrics under aim 2.	See CHT metric targets under aim 2.
			Provide practices and payers with tools to easily and accurately identify high-risk patients through the Integration and Alignment initiative	TBD – We are in the process of convening stakeholders to identify deliverables that will be of value to the provider community. Once deliverables are identified, we will establish metrics	TBD
	Increase use of data to drive	Maximize the use of HealthFacts RI, Complete the Common Provider	Maximize the use of HealthFacts RI: Support and maintain the claims data collection process; support	# of publicly available reports released from HealthFacts RI per year	6

AIM	PRIMARY DRIVER	SECONDARY DRIVER	INTERVENTIONS	METRIC(S)	TARGET(S)
	quality and policy	Directory and Create a Health Care Quality Measurement, Reporting, and Feedback System to create a data infrastructure that can support VBP.	advanced reports and analytics; and support the coordination of data validation, release, and analysis	# of applications/requests for level 2 or level 3 data extracts from HealthFacts RI per year	10
1. REDUCE RATE OF INCREASE IN RHODE ISLAND HEALTHCARE SPENDING, continued	Increase use of data to drive quality and policy continued	Maximize the use of HealthFacts RI, Complete the Common Provider Directory and Create a Health Care Quality Measurement, Reporting, and Feedback System to create a data infrastructure that can support VBP. continued	Complete the Common Provider Directory: Consolidate provider data from multiple sources into a single "source of truth" record; increase the understanding of provider-to-organization relationships; Provide a public portal to search for and locate providers; Provide mastered provider data extracts to integrate into state systems.	CUM # of state agencies using common provider directory	5
				CUM # of private sector health care organizations using common provider directory	15
			Create a Health Care Quality Measurement, Reporting, and Feedback System that will consolidate quality reporting requirements and facilitation in one place to reduce the reporting burden on providers; Create a provider benchmarking and feedback system to communicate quality back to those who provide care; Provide quality information to the public to support making informed healthcare decisions.	CUM # of health care organizations/practices sending data to the Health Care Quality Measurement, Reporting and Feedback system.	10 or more
				CUM # of health care organizations/practices receiving data from the Health Care Quality Measurement, Reporting and Feedback system.	10 or more
		Enhance state agencies' data and analytic infrastructure by modernizing the state's current Human Services Data Warehouse	Modernize the state's current Human Services data Warehouse to create an integrated data ecosystem that uses analytic tools, benchmarks, and visualizations;	N/A	N/A
			Carry out qualitative and quantitative evaluation of the effect of alternative payment models in use in Rhode Island and the value of more closely aligning the models across payers	N/A	N/A
			Work collaboratively with state and community partners to encourage wider clinical data capture (particular focus on BMI) through the Integration and Alignment initiative	TBD	TBD

AIM	PRIMARY DRIVER	SECONDARY DRIVER	INTERVENTIONS	METRIC(S)	TARGET(S)
2. SUPPORT PROVIDER PRACTICE TRANSFORMATION AND IMPROVE HEALTH CARE PROVIDER SATISFACTION	Maximize & support team-based care	Using plan design, regulatory and purchasing/contracting levers, and SIM investments, maximize support for integrated team-based models of care	Create up to 3 new CHTs; Investigate the need for a more formal CHT training and certification program, including Screening, Brief Intervention, and Referral to Treatment (SBIRT); Provide training to providers (PCPs, CMHCs and hospitals) to better incorporate CHTs into their practices;	Number of active SIM-funded CHTs	2
				Percent of new, SIM-funded CHTs actively seeing patients	100%
				Number of unique practices utilizing new, SIM-funded CHTs	5-10
2. SUPPORT PROVIDER PRACTICE TRANSFORMATION AND IMPROVE HEALTH CARE PROVIDER SATISFACTION Support health care providers in their transition to delivering health care in an environment in which the care is paid for according to a value-based payment arrangement. SIM will invest in work place transformation activities that build upon the professional expertise of x% of Rhode Island's healthcare workforce. continued	Maximize & support team-based care continued	Using plan design, regulatory and purchasing/contracting levers, and SIM investments, maximize support for integrated team-based models of care continued	Create up to 3 new CHTs; Investigate the need for a more formal CHT training and certification program, including Screening, Brief Intervention, and Referral to Treatment (SBIRT); Provide training to providers (PCPs, CMHCs and hospitals) to better incorporate CHTs into their practices; continued	Number of CHTs participating in the statewide CHT consolidated operations model	4
				Percentage of completed data reports submitted by consolidated operations team	100%
				Number of provider trainings delivered about practice transformation and CHT benefits	50
				Percentage of tools and assessments made available to all CHTs in RI that are adopted by intended CHT recipients	TBD
				Percentage of patients referred to applicable CHTs who received services (A: SIM-funded; B: Non-SIM-funded)	100% *Note this target is highly aspirational since patients are free to choose whether to receive services or not.*
				Percentage of patients referred to and seen by applicable CHTs who then enrolled in CurrentCare	100%
				Percentage of patients referred to and seen by applicable CHTs who received an annual influenza vaccination	100%
				Number of Community Health Workers certified through the Rhode Island Certification Board	65

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				Percentage of CHTs employing Certified Community Health Workers	100%
				Number of patients in provider panels with referral ties to SIM CHTs	TBD
				Percent of RI residents with access to CHT (SIM funded + Existing)	TBD
2. SUPPORT PROVIDER PRACTICE TRANSFORMATION AND IMPROVE HEALTH CARE PROVIDER SATISFACTION continued	Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce	Make investments in the following programs for practice transformation: Community Health Teams (CHTs), PCMH Kids, Child Psychiatry Access Program, Integrated Behavioral Health & PCMH-Kids, Community Mental Health Center supports, and Health Care Quality Measurement, Reporting, and Feedback System	Support the PCMH expansion to 9 pediatric sites	CUM # of practices participating in the pediatric PCMH program	9
				CUM # of clinicians participating in the pediatric PCMH program	75
				CUM # of patients attributed to practices participating in the pediatric PCMH program	30000
			Provide child psychiatry consultation services to pediatric primary care providers; Train PCPs to expand their ability to treat some behavioral health needs in their practices	CUM # of pediatric primary care practices that have on-demand access to pediatric mental health consultation services	40
				CUM # of pediatric primary care practitioners who have on-demand access to pediatric mental health consultation services	200
				CUM # of pediatric primary care providers who have received consultation to provide basic psychiatric assessment and treatment services	200
				CUM # of patients served under the Child Psychiatry Access Program	7500
			Support integration of behavioral health into primary care by providing resources and training for SBIRT in PC practices and evaluation/data collection for 12 Integrated Behavioral Health Model practices.	CUM # of providers who have been trained in SBIRT	250
				CUM # of practice sites participating in integrated behavioral health initiative	12

AIM	PRIMARY DRIVER	SECONDARY DRIVER	INTERVENTIONS	METRIC(S)	TARGET(S)
			Build workforce capacity to maximize the use of existing tobacco cessation resources through the Integration and Alignment initiative	TBD	TBD
			Support CMHCs with practice transformation and to receive data about their patients	CUM # of CMHCs that received provider coaching	8
				CUM # of CMHCs with real-time ED and inpatient dashboards in use	8
				CUM # of providers trained to use dashboards at CMHCs	120
2. SUPPORT PROVIDER PRACTICE TRANSFORMATION AND IMPROVE HEALTH CARE PROVIDER SATISFACTION, continued	Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce	Make investments in the following programs for practice transformation: Community Health Teams (CHTs), PCMH Kids, Child Psychiatry Access Program, Community Mental Health Center supports, and Health Care Quality Measurement, Reporting, and Feedback System	Assist providers in aggregating data from their Electronic Health Records, to help make reporting and practice transformation easier; Provide training to providers in how to interpret the data to make positive changes within their practices; Pursue making this quality data available to patients.	Provide learning sessions for providers on interpreting data from the Healthcare Quality Measurement Reporting and Feedback System and how to use it for quality improvement.	At least 2 learning sessions held by 2018, and an additional 4 sessions by 2019.resources (if outside the CMHC).
3. EMPOWER PATIENTS TO BETTER ADVOCATE FOR THEMSELVES IN A CHANGING HEALTHCARE ENVIRONMENT AND TO IMPROVE THEIR OWN HEALTH Engage and educate patients to participate more effectively in their own health care in order for them to	Provide access to patient tools that increase their engagement in their own care. Assist with advanced illness care planning	Patient engagement tools or processes	Create or implement existing processes or tools that allow patients more control of their health and healthcare decision-making; Train providers and patients in how to use these tools to maximize their effectiveness	Metrics TBD, when procurement is complete (likely 8/1/2017)	Targets TBD within 6 months
			Use Community Health Teams to help implement Patient Empowerment tools	Metrics TBD, when procurement is complete (likely 8/1/2017)	Targets TBD within 6 months

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live healthier lives. Invest in tools (e.g., online applications, patient coaches – appropriate for the patient's demographic profile) to teach patients how to navigate effectively in an increasingly complicated health care system.		End-of-Life/Advanced Illness Care Initiative outreach, and patient and provider education	Increase the number of Rhode Islanders with Advance Directives through training of providers and patients; Determine whether Rhode Islanders can upload their Advance Directives to Current Care	Metrics TBD, when procurement is complete (likely 8/1/2017)	Targets TBD within 6 months