<table>
<thead>
<tr>
<th>High Level Clinics Approach Logic Model</th>
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<tbody>
<tr>
<td><strong>EHF Inputs</strong></td>
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<tr>
<td><strong>Resources:</strong></td>
</tr>
<tr>
<td>• Technical Assistance</td>
</tr>
<tr>
<td>• Training/Learning Collaboratives</td>
</tr>
<tr>
<td>• Research and Evaluation</td>
</tr>
<tr>
<td><strong>Funding Mechanisms:</strong></td>
</tr>
<tr>
<td>• Multi-year project funding</td>
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<tr>
<td>• One-time TA support</td>
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<tr>
<td>• One-time collaboration and planning</td>
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<tr>
<td><strong>Collaborations:</strong></td>
</tr>
<tr>
<td>• Clinic collaborations/partnerships to</td>
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<tr>
<td>create scale and efficiencies</td>
</tr>
<tr>
<td>• Funders and philanthropy</td>
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<tr>
<td>• Managed care/payers</td>
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<tr>
<td>• Community based/service organizations</td>
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<tr>
<td>• Gov't (local and statewide)</td>
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<tr>
<td>• Health systems/hospitals</td>
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| **EHF Inputs**                          |
| **Strategies**                          |
| Address gaps in capacity that impact   |
| the planning and implementation of     |
| population health strategies and value-|
| based approaches.                      |
| Address clinic strategic, financial    |
| and operational infrastructure and     |
| capacity to progress all three Levels  |
| of development.                        |
| Clinics build and expand data collection and analytics to support SDOH, population health and value-based models. |
| Clinics invest in performance          |
| measurement and outcomes tracking      |
| across clinical, operational, and      |
| financial domains                     |
| Clinics build partnerships with        |
| stakeholders who support population    |
| health strategies.                     |

| **Outputs**                             |
| **During Grant Period**                 |
| Clinics have clinical and operational  |
| workflows in place that support        |
| population health efforts.              |
| Clinics have demonstrated               |
| organizational effectiveness and        |
| commitment to the priority payment     |
| reform domains.                        |
| Clinics capacity to capture new data   |
| sets (i.e. SDOH, cost, etc.).           |
| Clinics implement innovative pilots for |
| upstream models of intervention and     |
| population health.                      |
| Clinics invest time and resources into |
| organizational change.                  |

| **Short-Term Outcomes**                 |
| **1-3 Years**                          |
| Clinics and their partners are using   |
| shared data to inform population health|
| efforts (including risk, cost, and      |
| utilization data).                      |
| Clinics have demonstrated               |
| financial sustainability potential to   |
| move them from Level 1 to Levels 2 & 3. |
| Clinics expand their infrastructure     |
| and clinical capacity over time to      |
| address SDOH, population health and     |
| upstream models.                       |
| Clinic leadership has developed an     |
| organizational culture that is          |
| committed to community prevention.      |
| Clinics have formal agreements with     |
| payers and others to engage in          |
| value-based models                      |

| **Long Term Outcomes**                  |
| **4 years & beyond**                    |
| Clinics and their community partners    |
| can demonstrate improvement in patients'|
| social and health needs.                |
| Clinics and their community partners    |
| can successfully demonstrate improved   |
| community health outcomes as well as    |
| positive ROI.                           |
| Community health prevention activities   |
| are sustainably funded                   |
| Culture of prevention and partnership   |
| is fully integrated in all strategies.   |
| Clinics demonstrate success under       |
| value-based payment arrangements,       |
| including taking on risk-bearing       |
| contracts.                             |

| **Key Assumptions:**                    |
| • Clinics have high adaptive capacity  |
| for changing their culture and         |
| organizational capabilities             |
| • Clinics will commit to moving from    |
| Level 1 through Level 3 as part of this |
| process                                 |
| • Clinics across the cohort will not    |
| start at the same point of development |

| **External Factors:**                    |
| • Policy directives from the State and   |
| Medicaid                                |
| • MCO/hospital appetite to engage and    |
| partner with clinics                     |
| • The uninsured rate in Texas            |
## Level 1 of the Clinics Approach

**Involves strengthening clinics’ capacity and infrastructure to begin engaging in population health management activities**

<table>
<thead>
<tr>
<th>EHF Inputs</th>
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<th>Outputs</th>
<th>Short-Term Outcomes</th>
<th>Long Term Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providing grants to fill specific gaps in clinics’ capacity to do population health management work; providing grants for one-time collaboration and planning efforts</td>
<td>Clinics use grant funding to address specific organizational gaps in their ability to do population health management work</td>
<td>Clinics have captured broad patient data set, including screening for patient SDOH needs and data used for clinical planning and identifying population health priorities</td>
<td>Clinics have strengthened their capacity to engage in population health management though increased capacity in several core competency areas (organizational commitment, clinical management and care management program; SDOH, health IT and data analytics, financial health and planning)</td>
<td>Clinics advance to level 2.</td>
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<tr>
<td>Facilitating effective technical assistance by identifying consultants and resources</td>
<td>Clinics actively participate in or lead the development of peer learning opportunities around how to do population health management</td>
<td>Clinics have established appropriate staffing to do population health management (either through recruiting new staff or training existing staff)</td>
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<tr>
<td>Facilitating learning collaboratives and peer learning opportunities (including coordinated work with other funders)</td>
<td>Clinics develop an infrastructure to systematically and effectively capture patient data, specifically quality outcomes and SDOH data</td>
<td>Demonstrated organizational commitment to key payment reform readiness domains through demonstrated leadership-led planning for population health, SDOH, and other core competency areas.</td>
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<tr>
<td>Convene collaborators and stakeholders (i.e. payers, CBOs, government, etc.) to support population health efforts</td>
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<tr>
<td>Conducting in-depth research and evaluations focused on what works for whom and why</td>
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### Key Assumptions

- Participating clinics must have a high degree of willingness and a reasonable level of readiness to engage in population health management activities, as well as participate in EHF training/TA
- Clinics in Level 1 will commit to moving through Level 1 to Levels 2 and 3 as part of this process
- Clinics across the cohort will not start at the same point in their development but are expected to determine baseline capacity and gaps to implement strategies
### Level 2

Level 2 of the clinics approach involves supporting clinics as they undertake population health management activities (that incorporate addressing unmet social needs) with their patient population.

#### EHF Inputs

| Providing grants to fund clinics to enhance their population health management work as well as collaboration and planning efforts |
| Providing or identifying technical assistance resources |
| Conducting environmental scans or research on various payment and delivery models (ACOs, APMs, etc.) |
| Conducting environmental scans or research on clinic partnership opportunities |
| Conducting in-depth research and evaluations focused on what works for whom and why |
| Convene collaborators and stakeholders (i.e. payers, CBOs, government, etc.) to support population health efforts |

#### Strategies

| Clinics are using grant dollars to improve their population health management work |
| Clinics maximize existing alternative payment programs |
| Clinics are beginning to develop partnerships with key stakeholders (MCOs, hospitals, CBOs) |
| Clinics quantify and articulate their ROI to partners (their value proposition) |
| Clinics identify key clinical outcomes to be improved upon |
| Clinics expand care coordination and empanelment efforts |

#### Outputs During Grant Period

| Clinics use hotspotting/risk stratification to target interventions to population subgroups |
| Clinics are implementing a closed-loop referral process for patients with unmet social needs |
| Clinics are engaging in social-risk targeted care activities in support of chronic disease management (i.e. home remediation for asthma) |
| Clinics formalize partnerships with MCOs, partners, and hospitals to engage in APMs or other population health activities (i.e. ED diversion) |
| Clinics have a formal agreement in place to support bi-directional data sharing with partners, including payer data to support clinical and population health planning |
| Clinics are implementing a standardized SDOH screening process |

#### Short-Term Outcomes 1-2 Years

| Clinic care protocols are influenced by patient risk scores and social needs assessment findings |
| Patients can access additional services to address their unmet social needs |
| Clinics are engaging in social-risk targeted care activities in support of chronic disease management (i.e. home remediation for asthma) |
| Clinics formalize partnerships with MCOs, partners, and hospitals to engage in APMs or other population health activities (i.e. ED diversion) |
| Clinics have a formal agreement in place to support bi-directional data sharing with partners, including payer data to support clinical and population health planning |
| Clinics are implementing a standardized SDOH screening process |

#### Long Term Outcomes 2-3 Years

| Clinics identify and obtain non-philanthropic funding sources to support population health management activities |
| Patient’s social needs are improved |
| Clinics demonstrate improved health outcomes |
| Clinics draw down available P4P and/or other APM funding and can re-invest in infrastructure for population health, SDOH, and value-based activities |
| Clinics organizational commitment to population health expanded through additional partnerships and strategies (i.e. hiring of additional staff, etc.) |
| In collaboration with partners, clinics can quantify both the impact of addressing and not addressing unmet patient SDOH needs |

#### Note 1: Clinic partnership continuum:
- Partnerships with community-based agencies and organizations (local government and nonprofit)
- Partnerships with hospitals
- Consortiums
- Management services organizations and clinically integrated networks
- Health-center-led Independent Practice Associations (IPAs)
- Partnerships with health plans
- Mergers and acquisitions

#### Key Assumptions

- Clinics have robust infrastructure in place for population health management
- Clinic business models reflect an attention to issues such as payer mix, patient population size, etc.

#### External Factors

- Policy directives from state Medicaid
- The uninsured rate in Texas
- MCO/Hospital appetite to engage/partner with clinics to do this work
### Level 3

Level 3 of the clinics approach involves supporting clinics to work with payors, hospitals, and other stakeholders to develop strategies to sustainably finance community prevention work.

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<tbody>
<tr>
<td>Facilitating and brokering collaborations between clinics and key stakeholders (MCOs, hospitals, CBOs)</td>
<td>Clinics are using grant funds to catalyze experimentation with community health prevention work, rather than just building capacity</td>
<td>Clinics use, vet, experiment, or pilot innovative models for community prevention</td>
<td>Clinic leadership has developed an organizational culture committed to community prevention</td>
<td>Clinics can successfully demonstrate improved community health outcomes as well as positive ROI</td>
</tr>
<tr>
<td>Research on innovative models to sustainably finance community prevention as well as how to develop strong multi-sector collaboratives</td>
<td>Clinics are partnering with a diverse array of multi-sectoral stakeholders on community health prevention work</td>
<td>Clinics implement an integrated referral and follow up system to address SDOH</td>
<td>Clinics have infrastructure in place that positions them to be active partners in addressing social determinants of health</td>
<td>Clinics leverage partnerships with hospitals, MCOs, local governments to support community prevention</td>
</tr>
<tr>
<td>Systems mapping of assets and resources</td>
<td>Clinics incorporate community-level metrics into planning and evaluation</td>
<td>Clinics expand financial capacity to implement of value-based and risk-based arrangements</td>
<td>Clinics articulate the public health impact of unmet social and health needs as well as value-proposition for how they can address those needs to payers and partners</td>
<td>Community health prevention activities are sustainably funded</td>
</tr>
<tr>
<td>Conducting in depth evaluations focused on what works for whom and why</td>
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**Key Assumptions**
- Clinics have high adaptive capacity for changing their culture and their infrastructure/capacity is robust and fully built.
- EHF is in this for the long game

**External Factors**
- Policy directives from state Medicaid
- The uninsured rate in Texas
- MCO/Hospital appetite to engage/partner with clinics to do this work

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11/12/2019