High Level Clinics Approach Logic Model

EHF Inputs	Strategies	Outputs During Grant Period	Short-Term Outcomes 1-3 Years	Long Term Outcomes 4 years & beyond
Resources: • Technical Assistance • Training/Learning Collaboratives • Research and Evaluation	Address gaps in capacity that impact the planning and implementation of population heath strategies and value-based approaches.	Clinics have clinical and operational workflows in place that support population health efforts.	Clinics and their partners are using shared data to inform population health efforts (including risk, cost, and utilization data).	Clinics and their community partners can demonstrate improvement in patients' social and health needs.
Funding Mechanisms: • Multi-year project funding • One-time TA support • One-time collaboration and planning efforts	Address clinic strategic, financial and operational infrastructure and capacity to progress all three Levels of development.	Clinics have demonstrated organizational effectiveness and commitment to the priority payment reform domains.	Clinics create financially sustainable models that move them from Level 1 to Levels 2 & 3.	Clinics and their community partners can successfully demonstrate improved community health outcomes as well as positive ROI.
Collaborations: • Clinic collaborations/ partnerships to create scale and efficiencies • Funders and philanthropy • Managed care/payers • Community based/service organizations • Gov't (local and statewide) • Health systems/hospitals	Clinics build and expand data collection and analytics to support SDOH, population health and value-based models.	Clinics capacity to capture new data sets (i.e. SDOH, cost, etc.).	Clinics expand their infrastructure and clinical capacity over time to address SDOH, population heath and upstream models.	Community health prevention activities are sustainably funded
	Clinics invest in performance measurement and outcomes tracking across clinical, operational, and financial domains	Clinics implement innovative pilots for upstream models of intervention and population health.	Clinic leadership has developed an organizational culture that is committed to community prevention.	Culture of prevention and partnership is fully integrated in all strategies.
	Clinics build partnerships with stakeholders who support population health strategies.	Clinics invest time and resources into organizational change.	Clinics have formal agreements with payers and others to engage in value-based models	Clinics demonstrate success under value-based payment arrangements, including taking on risk-bearing contracts.
		Clinics and their community partners have closed loop referral and care management programs that integrate across systems.		

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

Level 1 of the Clinics Approach involves strengthening clinics' capacity and infrastructure to begin engaging in population health management activities

EHF Inputs	Strategies	Outputs During Grant Period	Short-Term Outcomes 1-2 Years	Long Term Outcomes 2-3 years
Providing grants to fill specific gaps in clinics' capacity to do population health management work; providing grants for one-time collaboration and planning efforts	Clinics use grant funding to address specific organizational gaps in their ability to do population health management work	Clinics have captured broad patient data set, including screening for patient SDOH needs and data used for clinical planning and identifying population health priorities	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)	Clinics advance to level 2.
Facilitating effective technical assistance by identifying consultants and resources	Clinics actively participate in or lead the development of peer learning opportunities around how to do population health management	Clinics have established appropriate staffing to do population health management (either through recruiting new staff or training existing staff)		
Facilitating learning collaboratives and peer learning opportunities (including coordinated work with other funders)	Clinics develop an infrastructure to systematically and effectively capture patient data, specifically quality outcomes and SDOH data	Demonstrated organizational commitment to key payment reform readiness domains through demonstrated leadership-led planning for population health, SDOH, and other core competency areas.		
Convene collaborators and stakeholders (i.e. payers, CBOs, government, etc.) to support population heath efforts				
Conducting in-depth research and evaluations focused on what works for whom and why				

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	Strategies	Outputs During Grant Period	Short-Term Outcomes 1-2 Years	Long Term Outcomes 2-3 Years
Providing grants to fund clinics to enhance their population health management work as well as collaboration and planning efforts	Clinics are using grant dollars to improve their population health management work	Clinics use hotspotting/risk stratification to target interventions to population subgroups	Clinic care protocols are influenced by patient risk scores and social needs assessment findings	Clinics identify and obtain non-philanthropic funding sources to support population health management activities
Providing or identifying technical assistance resources	Clinics maximize existing alternative payment programs	Clinics are implementing a closed-loop referral process for patients with unmet social needs	Patients can access additional services to address their unmet social needs	Patient' social needs are improved
Conducting environmental scans or research on various payment and delivery models (ACOs, APMs, etc.)	Clinics are beginning to develop partnerships with key stakeholders (MCOs, hospitals, CBOs)[1]	Clinics are engaging in social-risk targeted care activities in support of chronic disease management (i.e. home remediation for asthma)	Clinics and their respective partners are using shared data to inform population health improvement efforts	Clinics demonstrate improved health outcomes
Conducting environmental scans or research on clinic partnership opportunities	Clinics quantify and articulate their ROI to partners (their value proposition)	Clinics formalize partnerships with MCOs, payors, and hospitals to engage in APMs or other population health activities (i.e. ED diversion)[1]	Clinics draw down available P4P and/or other APM funding and can re-invest in infrastructure for population heath, SDOH, and value-based activities	In collaboration with partners, clinics can quantify both the impact of addressing and not addressing unmet patient SDOH needs
Conducting in-depth research and evaluations focused on what works for whom and why	Clinics identify key clinical outcomes to be improved upon	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 organizational commitment to population health expanded through additional partnerships and strategies (i.e. hiring of additional staff, etc.)	
Convene collaborators and stakeholders (i.e. payers, CBOs, government, etc.) to support population heath efforts	Clinics expand care coordination and empanelment efforts	Clinics are implementing a standardized SDOH screening process		

Note 1: Clinic partnership continuum: Partnerships with community-based agencies and organizations (local government and nonprofit); Partnerships with hospitals; Consortia; 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

EHF Inputs	Strategies	Outputs During Grant Period	Short-Term Outcomes 1-3 Years	Long Term Outcomes 4 years & beyond
Facilitating and brokering collaborations between clinics and key stakeholders (MCOs, hospitals, CBOs)	Clinics are using grant funds to catalyze experimentation with community health prevention work, rather than just building capacity	Clinics use, vet, experiment, or pilot innovative models for community prevention	Clinic leadership has developed an organizational culture committed to community prevention	Clinics can successfully demonstrate improved community health outcomes as well as positive ROI
Research on innovative models to sustainably finance community prevention as well as how to develop strong multi-sector collaboratives	Clinics are partnering with a diverse array of multi-sectoral stakeholders on community health prevention work	Clinics implement an integrated referral and follow up system to address SDOH	Clinics have infrastructure in place that positions them to be active partners in addressing social determinants of health	Clinics leverage partnerships with hospitals, MCOs, local governments to support community prevention
Systems mapping of assets and resources	Clinics incorporate community-level metrics into planning and evaluation	Clinics expand financial capacity to implement of value-based and risk-based arrangements	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	Community health prevention activities are sustainably funded
Conducting in depth evaluations focused on what works for whom and why				

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