

COMPENDIUM OF COMMENTS TO CCIP SECOND DRAFT

COMMENTER # 3

General comments re the contents of the Report to make it easier to read and use—knowing who is audience for this document would be a big help in deciding what goes in it)

- Length of document needs to be reduced significantly
- Reorganize document so focus on CCIP comes much earlier. Much of rest might be best as appendixes (if needed)
- An executive summary might be helpful
- Redundancies need to be reduced; reorganizing content might be helpful—a lot of what is included is really background and context and is not specific to the CCIP
- Terms need to be defined, clarified, etc. and then used consistently throughout
- The document content, definitions, etc should be clearly related to the CCIP program standards
- What CCIP is and its goals do not come through in narrative
- Need to clarify CCIP and its relationship to entire SIM effort, etc
- The tone of the document does not seem to reflect the patient centeredness of our dialogue

Some specific comments that relate to the above (many of these comments are things that I believe need to be addressed in other places in document -- I have given specific locations as illustrations):

In overview

- Term “whole-person-centered” is a bit odd- could you have partial person centered? I think person centered is adequate
- Concept of “superior access” is an odd one; I think the idea is that people should have access to right care, at right time with right provider, etc.
- Improves affordability is not helpful—affordability for whom? I think we are talking about cost-effective care—care that is cost-effective would reduce unnecessary costs
- Primary care is bedrock????? What does this mean?
- Why is it important to reader of this document to “understand how CT provides are organizing...”???? Not sure of purpose of rest of that paragraph.
- Relationship of CCIP initiative/program to care delivery reform is not clear to me. They look rather similar in the diagram
- I am not sure what “clinical care” term is supposed to mean; as this word creeps into several places, it needs clarity of definition and use. I believe you are referring to health care services as they are traditionally defined.
- The statement that lower cost as primary is not good. CCIP may not reduce costs- but certainly we hope it will contribute to cost effective care
- The introduction of “social circumstances” (I think you are getting at social determinants of health with this?) and population health in this section starts mixing up population health initiatives and personal health care initiatives (what CCIP and AMH are about when they are patient centered)
- Diagram with advanced network in middle should have THE PERSON/PATIENT in the middle
- In section “Which Providers will participate..” is Medicaid participation required? I thought they were waiting. I think it is not quite right to say the providers participating in CCIP will have strong incentives to perform well--- it makes it could like other providers don’t !! (We trust—or at least want to believe-- that all providers want to do what is best!!)
- Program design process section-
 - What does the term capabilities mean? Are these expectations? Competencies? Processes?

- Individual care and population health issues are both in the “capabilities” list. I thought the CCIP was focused on care of patient care and that the population health issues like reducing inequities were not a direct objective of the CCIP
- Last sentences that leads with however???????
- Guiding principles and program recommendations are not aligned – terminology is confusing (such as clinical and non-clinical, whole-person, etc)
- How do standards introduce processes?
- Need to clarify how standards related to patient care vs community; there have to be different goals and outcomes? The core and elective standards figure is confusing. What are the boxes and how do they relate to CCIP?

In CT State Innovation Model Background

- Much of what is stated above applies here as well
- Person centeredness concept needs to be better reflected in the resto of document
- Please include other care providers in the discussions—all PCPs (and others), not just physicians are accountable for cost and quality of care they provide!!
- The unlabeled (?org chart) need labelling and clarity re relationships of the various boxes to one another—not sure if you need anyway

In role of the PTF section

- The issue of affordable needs clarification; affordable to whom? patient, society? Not sure if that is best term to use!!
- Graphic needs labels, fewer words in it; terms need clarification and alignment with what is said in other parts of document
- The clinical, non-clinical, etc. terms related to care are inconsistent and unclear; also, new terms such as “good clinical care” are introduced. Behavioral health and oral health are NOT “supportive” clinical services—very confusing terminology in that paragraph and does not, I believe, reflect where the PTF has been in its deliberations

In CCIP design and implementation approaches section

- Initial process- see earlier comments re terms and definitions; what does “most impactful” mean?
- Table one – clarify what it is; is it evidence re who the capability contributes to the objectives? If so, the objectives need to be included.
- Not sure what an “extended design process” is???
- Were we really promulgating EBP standards? Perhaps were were identifying them?
- **High needs definition is major issue for this work—here are some issues**
 - Conditions are not all medical; complexity arises from a verity of domains
 - Need to discuss complex care needs (see some AHRQ definitions for reference)
 - Definition needs to focus on and arise with patient; it is not a patient centered, patient friendly definition!!
 - Need to differentiate acute, chronic, continuum of care
 - The statement that these individuals have frequent visits... should not be included in definition! “As a result” is not part of a definition—it takes wrong tone!

In CCIP implementation approach section:

- See also earlier comments
- Clarify term “impactful”

- Capabilities that follow list of capabilities on p. 12 need clarification (ex. # 11 are different “capabilities”). I think part of problem relates to clarity with what a capability is in this document
- The discussion of IT is confusing here; what does it mean for SIM, it seems to come in out of the blue.

CCIP Focus Population Definitions section:

- This section needs a lot of attention and alignment with other documents and as reflected in above comments. There are many terminology, definitional, etc issues.
- There are conceptual issues- it is not clear what “patients experiencing equity gaps” means- generally one refers to population inequities; further confusing me are use of terms population, sub-population, etc.
- How are patients with unidentified behavioral health needs are to be found!! If the needs are unidentified..... I think you may mean unmet? Not assessed? Also, I think embedded in discussions that follow is some blending of mental health needs and people with complex conditions rather than having them as distinct groups as represented in tables, figures and text (sometimes).

Section 5 and Appendices also reflect the issues identified above. Until the definitional and conceptual issues are straightened out it will be difficult to assure that the standards and measures are appropriate to the goals and expectations of the prescribed interventions.

COMMENTER # 5

Complex Patients: Individuals who have (or are at risk for) multiple complex health conditions, **multiple detrimental social determinants of health**, or a combination of both that contribute to preventable service utilization and poorer overall healthcare management that negatively impacts the individual’s overall health status.

PTTF’s definition is flawed. Across the US, patients with complex health care needs are defined as individuals who have **multiple chronic conditions that require a number of medical services coordinated across multiple providers, as well as the need for a wide range of social supports to maintain health and ability to perform daily life functions**....patients with 5 or more chronic conditions tend to be the most costly(according to Robert Woods Johnson study), and PCMHs can lower the cost of caring for these patients with the help of a care coordination services or a **comprehensive care team** that can effectively coordinate the full range of medical, mental health, and social servicespatients with an acute condition or a single uncomplicated chronic condition (such as asthma or diabetes)and **multiple detrimental social determinants of health** may be at high-risk for hospitalization, multiple ER visits, or hospital re-admissions due an uncontrolled medical condition in the short-term..... but they are NOT truly complex patients and offering comprehensive care management services to these patients does not result in long term cost savings!!(Robert Woods Johnson study)

Attached are my recommendations for changes to pages 18 and 19....

CCIP Detailed Intervention Design: Core and Elective Interventions

Core Interventions for High Needs Populations

Individuals with Complex Needs

Care coordination for individuals with complex needs is a key component of CCIP. In a medical home, the amount of care coordination required for each individual depends on the complexity of his or her *healthcare* needs. For individuals with less complicated medical conditions, the primary care team is usually able to effectively coordinate patient care as part of the routine clinical care process. The primary care team consists of the patient, the patient's designated family members or other supports, a physician or APRN, and other staff of the medical home. As the complexity of the patient's needs increase, the primary care team may not be able to fully assess the needs of a complex patient or effectively coordinate care—the primary care team must enhance the care management with additional participants such as a care manager, specialist, pharmacist, behavioral health specialist, or community health worker. We refer to this enhanced care team as a *comprehensive care team*.

Members of the comprehensive care team are responsible for doing a comprehensive "whole" person needs assessment and then using this assessment.....to *develop an individualized care plan for the patient that takes into account all of the patient's healthcare needs along with patient/family/caregiver preferences, needed social services and community supports. Since many complex patients (especially the disabled or elderly) have functional limitations, a direct assessment of the home is often needed to detect barriers to care..... Many patients with complex health care needs have chronic conditions that are slowly progressive which means they will often need life-time (or long-term) assistance from family members or community health workers with day-to-day life activities..... In addition, complex patients often need help accessing public benefit programs (such as Medicaid or food stamps), with payer authorizations (sometimes on a monthly basis), scheduling appointments with multiple providers, access to assistive technology, or obtaining needed durable medical equipment (canes to wheelchairs needed to provide mobility and independence), long-term physical or occupational therapy, transportation to medical appointments or shopping, medication, or even home-delivered meals from community based services. The burden of repeatedly documenting a patient's ongoing need for these services places too great on an primary care team!..... (I would avoid these last 2 sentences since most REAL complex patients will never truly transition out of the complex care team to self-management programs...the CCT team can help improve their medical conditions to the point where this population will have fewer hospitalizations, ER visits, re-admissions, etc)*

Care Model Research and Design for Individuals with Complex Needs

In the background research for our complex care management standards, we examined a number of model programs that have excelled in the provision of care for individuals with exceptional care management needs, often with multiple social determinant risks such as unstable housing or joblessness. Unlike the complex care management standards that are the focus of CCIP, these programs may be comprised of teams and care plans that are *not* centered on the medical home (e.g., programs targeting individuals with serious and persistent mental illness, chronic substance abuse, developmental disabilities, or populations that require a range of long term services and supports). Although we have learned a great from our examination of these programs, it is important to emphasize that our focus in CCIP is on those individuals for whom the primary care team is the foundation for the care management process and the source of continuous support when the comprehensive care team is no longer required.

Many of the innovative care management models around the country identify the needs of patients who are considered complex (The Center for Health Care Strategies, Inc., 2014). Although none of the programs reviewed are exactly the same, they share a similar intensive care management design. The intensive care management models tend to consist of a care management team that deploys similar tools (e.g., needs assessments and care plans) to provide intensive care management. Often the core objective of a care management team is to focus on in-person care management and the integration of primary care and community resources.

Successful care management is accomplished when individuals are engaged in their care, feel supported by their providers, and have their full range of clinical and non-clinical needs addressed. The common tools used by these

teams include needs assessments and care plans. The needs assessments are used to identify clinical, social, and behavioral health needs. A person-centered care plan supports the individual in achieving care goals by ensuring transparency, portability, and continuity of information about health conditions, personal preferences, and goals of care (Spencer A, 2015) (Samuelson, 2015) (Hawthorne, 2015) (Health, 2014).

At a high level the following **program design** is commonly used:

1. Identify the focus population; *with the help of referrals or data analysis*
2. *(Care coordination for complex patients starts with) Dedicated (complex care), trained care manager/management team conducts a comprehensive assessment of the individual's need for health supports and social services*
3. *Develops an **individualized health care plan** for the patient with input from the primary care team, patient, patient's family and caregivers....and creates a program for updating the care plan*
4. *Form a **comprehensive care team** to address patient's individualized needs*
5. *Communicate care plan to PCP, patient, family, care givers, providers, and community support services; and engage patient and patient's family/caregivers in self-management goals*
6. Execute the care plan; ensure updates are communicated to the care team *(including the patient, family, and caregivers)*; connect the individual to needed clinical and non-clinical services: and support the individual to transition to routine primary care team follow-up and *engage patient, family, and caregivers in plan to meet self-directed care management goals; and*
7. ***Patients in a complex care program must be re-assessed on an on-going basis to ensure that they are receiving the correct or "right" level of intervention (recommended: every 6-12 months or whenever there is a change in the patient's needs or condition)***
8. Track the individual, *periodically reassess, and evaluate self-management skills—(some patients may be able to improve skills with telephonic support but others may need face-to-face clinic or home visits)*
9. *When transitioning patients between levels of care, assess the patient's care plan goals and conduct a care team meeting (including PCP, patient, family and caregivers) to reach consensus*
10. *Develop training modules for care team, community supports, and patient*
- 11.
- 12.

A set of **design questions** was used to inform the creation of standards for CCIP. The main design questions included the following:

1. How should networks identify complex patients?
2. Who will the core members of the comprehensive care team be? What will be their roles?
3. How will the network build the comprehensive care team workforce?
4. What type of training will comprehensive care teams and primary care practices require?
5. What will the needs assessment and care plan look like? How will they be administered?
6. How will the comprehensive care team support the patient to successfully meet the care plan goals?
7. How can networks monitor an individual's health status *when the patient attains the goal of improved self-directed care management?*
8. How will the networks monitor the effectiveness of the intensive care management intervention?
9. How will patient and caregiver preferences and input be incorporated into the care plan?

In answering these questions, the PTF drew on best practices identified in related state and national programs and their individual expertise and experiences as providers, payers, and consumers of healthcare in Connecticut. (See Appendix D for the review of state and national programs and the PTF's disposition of each design question.)

^{1[1]} Programs use multiple names for their care management teams, including: community care teams, integrated care delivery teams, community health teams, etc.

COMMENTS # 6

Page 7 end of first paragraph. The last sentence reads "The oral health standards are designed to increase oral health access and capabilities within the primary care setting" Please add "to improve both oral and overall health."

Diagram – 3rd box, add "s" to "intervention"

Page 10 chart – one of the most confusing ones I have seen for SIM and many of the parts are not explained who they are. Is this even needed?

Page 11, Note under diagram – (e.g. behavioral health providers) add "and dental providers"

Page 13, Table 1, Oral Health – Is this a direct quote from Qualis? If not, I would propose to replace it with "Prevention of and better treatment of oral diseases can lead to improved outcomes and lower costs for other healthcare conditions."

Page 17 – Patients Experiencing Equity Gaps – The definition needs improvement. It is not clear to readers. The first sentence is not a sentence. The rest is choppy and not inclusive.

Page 18 – Was the goal for this to only focus on patients with Unidentified behavioral health or also those with behavioral health issues that are affecting health conditions.

Page 43 – Suggested change for

Description: It is well documented that there is an oral-systemic link (Qualis, 2015). The oral health integration standards provides best-practice processes for the primary care practices to routinely perform oral health assessment with recommendation for prevention, treatment and referral to a dental home.

Objective: To improve oral for all populations with its associated impact on overall health. An individual's oral health affects their overall health and vice versa, in particular when individuals have certain chronic diseases such as diabetes, obesity, lung and heart diseases, as well as affected the birth outcomes. These standards put into primary care practices processes that promote treating the individual that acknowledges the oral-systemic link.

Standards: 1. First bullet

First sub-bullet should read: "The last time the individual saw a dentist and the service received."

Second sub-bullet should read: Name of dentist and location/dental home if available.

Page 44

First bullet on page – correct the spelling of “caries” (only one r for the disease)

Fourth bullet on page – change to read “Lesions including pre-cancer and cancerous lesions.”

Standard 3

First bullet should be followed by the first sub-bullet on the page 45. Then proceed to present second bullet.

Second bullet – first sub-bullet – should read: Providing products that support oral hygiene if available

Footnote 72 – change “subscription” to “prescription”

Page 45

Second sub-bullet at top of page – change “Crafting” to “Providing”

Under first bullet on the page,

the first sub-bullet , add a footnote: Medicaid patient and locations of safety-net facilities, contact CTDHP at 1-855-CT-DENTAL or <https://www.ctdph.com>

under the second sub-bullet, change the second sub-sub bullet to read: Current Medications, allergies and health conditions.

The fourth bullet, change “Receiving” to “Requesting” (we can only make the PCP responsible for requesting as it is up to the dental home to send it”

Standard 4, first bullet, second sub-bullet, change “exam” to “risk assessment and screening”

Page 46 – 48 I have many changes if to keep this, but I really think this should be changed to Telemedicine of which one part is electronic consulting. I am attaching supporting documents and files to improve this section.

Page 49

Objective: should “for improving” replace “improve” for easier reading?

Detailed Program Design – is it needed since you have Standards next like the other elective standards?

Standard 1. MTM – what is that?

Page 52

First sub-bullet – is the meeting in person? Or by what means? If other, maybe another term is better here than meeting.

COMMENTER # 7

SECOND DRAFT FOR DISCUSSION- 10-5-15

Introduction:

Utilization of telehealth (including telemedicine) to deliver health related services and resources is growing significantly on global, national and regional levels. As leaders across health care and public/community health systems continue to recognize the value of leveraging technology to achieve common goals around increased access to care, improved health outcomes, and cost effectiveness, the impetus for incorporating telehealth into existing practice and standards of care has strengthened considerably. Rapid advances in

technology have enabled more innovative, user-friendly and cost effective models for telehealth integration across the globe. However, a continued tendency to set telehealth apart from a policy perspective has resulted in ongoing barriers to wide-spread adoption and integration in the U.S. Telehealth is not a specific clinical service, rather a variety of means by which technology can be used to enhance the delivery of care and/or education.¹ This is an important distinction as our country continues to transition to a health care system which pays for outcomes versus services, yet shortages in provider resources continue to grow.

There are a number of well established benefits in using telehealth for both patients and providers:

- Increased patient access to providers due to reduced travel barriers, either for the patient or the provider
- Timelier access to providers, including decreased wait times for appointments with specialists
- Improved continuity of care and case management
- Reductions in the use of institutional care, including decreased reliance on emergency rooms
- Improved access to training and educational services for providers and patients
- Reductions or prevention of complications resulting from care provision earlier in the disease process
- Cost savings or cost containment in care delivery, such as savings from more efficient care delivery through reduced patient or provider travel costs
- Increased patient satisfaction

A large collection of peer-reviewed literature is available to support these benefits. The ATA Research Outcomes Report² highlights just a few of the 2,000 evaluative studies published in two telemedicine journals on cost effectiveness, quality of care, patient acceptance, and specialty focus areas. Similar resources are available through the Center for Connected Health Policy's Research Catalogues³, targeting specific specialties or outcomes. And many articles and other resources are available through the Northeast Telehealth Resource Center⁴, the regional Telehealth Resource Center covering Connecticut and seven other states, supported by HRSA's Office for Advancement of Telehealth to improve health access and outcomes through telehealth.

Despite existing hurdles with lack of consistent policy and reimbursement across states and payers, there has been significant legislative activity related to telehealth across the region, with over 80 bills submitted for consideration among eight northeastern states during 2014-2015 sessions. Connecticut was among those states passing telehealth bills into law, and on January 1, 2016, will become one of 29 states requiring parity among private payers for healthcare services delivered via telehealth. As defined in SB 467, which was signed into Connecticut law on June 23, 2015, "Telehealth means the mode of delivering health care or other health services via information and communication technologies to facilitate the diagnosis, consultation and treatment, education, care management and self-management of a patient's physical and mental health, and includes (A) interaction between the patient at the originating site and the telehealth provider at a distant site, and (B) synchronous interactions, asynchronous store and forward transfers or remote patient monitoring. Telehealth does not include the use of facsimile, audio-only telephone, texting or electronic mail".

While some gaps remain in regard to policy which supports wide-spread utilization of telehealth throughout the state, the new law does allow for use of multiple telehealth modalities, including synchronous (live videoconferencing) and asynchronous (store-and-forward) methods among a fairly comprehensive spectrum of providers. Further, the law does not specifically define, nor restrict eligible originating sites, as Medicare and many state Medicaid programs currently do, which has been a consistent barrier for implementation in the past.

There is a strong evidence-base and comprehensive collection of resources available to assist with planning, implementing and evaluating sustainable telehealth programs, many of which can be accessed at no cost. Coupled with local, regional and national efforts to effectively integrate telehealth solutions into strategic

plans for enhanced access to health related care, resources and education, it is anticipated that technology and telehealth will have a profound and lasting impact on the health and vitality of the population.

Comment: Not sure how the rest of the document reads, but the section below seems like a policy/procedure manual. If that is the intent, perhaps there should be consistent sections describing other telehealth models/modalities which are supported by the new law, such as live-videoconferencing for patient consultations (could be specialty and/or integration of Primary Care and mental health services) and store-and-forward for teledermatology and/or diabetic retinopathy screenings? NETRC could help with this, but would need more time.

Electronic Consults, or E-consults, are one example of telehealth approaches which can be utilized to connect physician to physician, via either live videoconferencing or asynchronous means, to expand access to specialty providers and to help ensure that limited provider resources are most appropriately utilized.

ELECTRONIC CONSULTS (E-consults) STANDARDS

Developed under guidance from the Practice Transformation Taskforce (PTTF) as part of the Connecticut State Innovation Model/Initiative

Program Description and Objective:

Description: E-consults are a telehealth approach in which Primary Care Providers (PCPs) consult with a specialist reviewer electronically via e-consult (does the network allow this be done either live or asynchronously?) prior to referring an individual to a specialist for a face to face non-urgent care visit. This service can be made available to all individuals within the practice and for all specialty referrals, but may be more appropriate for certain types of referrals such as cardiology and dermatology. E-consult provides rapid access to expert consultation. This can improve the quality of primary care management, enhance the range of conditions that a primary care provider can effectively treat in primary care, and reduce avoidable delays and other barriers (e.g., transportation) to specialist consultation.

Objective: Improve timely access to specialists, improve PCP and specialist communication, and reduce downstream costs through avoiding unnecessary in-person specialist consultations.

High-Level Program Design:

1. Identify individuals eligible for e-consult
 1. Primary care provider places e-consult to specialist provider
 2. Specialist determines if in person consult is needed or if additional information is needed to determine the need for in person consult
 3. Specialist communicates outcome back to primary care provider

Detailed Program Design:

Standards

1. Identify individuals eligible for e-consult
 - The network defines for which specialty they will do e-consults⁷⁸
 - The network involves the individual in the decision to utilize an e-consult and will send e-consults for all individuals who require the service of the designated specialty and

who. assent to e-consult, with the exception of individuals with urgent conditions and those who have a pre-existing relationship with a specialist

2. Primary care provider places e-consult to specialist provider

- The network designates with which specialty practice or specialty providers it will coordinate e-consults⁷⁹.

¹ <http://www.telehealthtechnology.org/sites/default/files/documents/Telehealth%20Definintion%20Frame%20for%20TRCs.pdf>

² <http://www.americantelemed.org/docs/default-source/policy/examples-of-research-outcomes---telemedicine's-impact-on-healthcare-cost-and-quality.pdf>

³ www.cchpca.org/research-catalogues

⁴ www.netrc.org/resource-library

⁷⁸ Policy reports done in Connecticut by UCONN and Medicaid explored the use of e-consults for Cardiology, Dermatology, Gastroenterology, Neurology, Orthopedics and Urology
(http://www.publichealth.uconn.edu/assets/econsults_ii_specialties.pdf;

http://www.publichealth.uconn.edu/assets/econsults_cardiology.pdf)

⁷⁹ If the network does not have specialists in their network, they may want to consider establishing an e-consult relationship with a set of designated specialist providers who are distinct from the specialty providers who would do the face to face consult. This will promote neutral decision making on the part of the specialist by eliminating the financial incentive to suggest a face to face visit. If the specialists are within the same network, this will not be necessary.

- In partnership with the specialty practice and/or providers, the network develops a standardized referral form that includes:
 - o Standard form text options to ensure important details are shared
 - o Free text options to the opportunity for the primary care provider to share additional details of importance (Kim-Hwang JE, 2010)
 - o The ability to attach images or other information that cannot be shared via form or free text
- The network in partnership with the specialty practice develops a technology solution to push e-consults to the specialty practice and/or providers designated to do e-consults⁸⁰
- The network develops a process and protocol to send e-consults to the designated specialty practice and/or providers that includes:
 - o Identifying an individual in the primary care practice responsible for sending the e-consult to the specialty practice and/or providers
 - o Setting a timeframe within which the e-consult should be sent post-primary care visit
 - o Establishing a payment method for the e-consult service⁸¹
- The specialty practice and/or provider develops a process and protocol to receive and review thee-consult that includes:
 - o Identifying a coordinator whose responsibility it is to receive and prepare the consult for review
 - o Setting a timeframe within which the e-consult has to be reviewed once received by specialty practice

3. Specialist determines if in-person consult is needed or if additional information is needed to determine the need for in-person consult

- The specialist triages the referral into one of three categories:
 - o The individual does not need a referral
 - o The individual may need a referral but additional information is needed from the primary care provider (i.e.; additional history, additional tests run, etc.)
 - o The individual needs an in-person visit

4. Specialist communicates outcome back to primary care provider

- The network in collaboration with the specialty practice develops processes and protocols for primary care and individual notification of e-consult outcomes that include:
 - o Setting a timeframe within which the specialist notifies the primary care practice of e-consult result regardless of the outcome

⁸⁰ Solutions will vary based on available technology to both primary care providers and specialists. Range of solutions include: faxing, secure messaging, direct messaging, EMR based solution

⁸¹ Currently Medicaid has limited reimbursement for e-consults. Additional exploration around expanded reimbursements is being investigated

- o Providing communication back to the primary care provider in the form of a consult note with information on how to handle the issue in the primary care setting when a consult is not needed
- o Identifying how the primary care provider will notify the individual that follow-up is needed and process for scheduling additional testing, if necessary
- o Identifying how the primary care practice will connect the individual to referral coordination services to schedule the visit, to confirm that a visit was scheduled and to ensure the necessary information from the specialist is shared with the primary care provider from the in-person consultation

COMMENTER # 8

COMPREHENSIVE MEDICATION MANAGEMENT INTERVENTION

Developed under guidance from the Practice Transformation Task Force (PTTF) as part of the Connecticut State Innovation Model Initiative

Program Description and Objective:

Description: The Comprehensive Medication Management (CMM) intervention will be an elective CCIP capability for patients with complex therapeutic needs who would benefit from a comprehensive personalized medication management plan. CMM is a system-level, person-centered process of care provided by credentialed pharmacists to optimize the complete drug therapy regimen for a patient's given medical condition, socio-economic conditions, and personal preferences. The CMM evidence-based model was approved by 11 national pharmacy organizations and is dependent upon pharmacists working collaboratively with physicians and other healthcare professionals to optimize medication use in accordance with evidence-based guidelines.² In the context of CCIP, the CMM intervention will be relevant for all patients who are experiencing difficulty managing their pharmacy regimen, who have complicated or multiple drug regimens, or who are not experiencing optimal therapeutic outcomes; this includes patients enrolled in CCIP with complex conditions and patients experiencing equity gaps.

Objective: To assure safe and appropriate medication use by engaging patients, caregivers/family members, prescribers, and other health care providers to improve medication-related health outcomes.

High-Level Program Design:

² Joint Commission of Pharmacy Practitioners. *Pharmacists' Patient Care Process*. May 29, 2014. https://www.accp.com/docs/positions/misc/JCPP_Pharmacists_Patient_Care_Process.pdf

1. Identify patients requiring comprehensive medication management.
2. Pharmacist consults with patient/caregiver in coordination with PCP or comprehensive care team.
3. Develop and implement a person-centered medication action plan.
4. Followup and monitor the effectiveness of the medication action plan for the identified patient.

Detailed Program Design:

Standards

1. Identification of patients requiring comprehensive medication management

- The network defines criteria to identify patients with complex and intensive needs related to their medication regimen that would be conducive to pharmacist intervention³;
- The network develops a process for the responsible professional and/or care team to assess patient medication management needs⁴

2. Pharmacist consults with patient and, if applicable, caregiver in coordination with PCP or comprehensive care team

- The Advanced Network or FQHC selects a pharmacist integration model that aligns with their current network needs/current state.⁵
 - Regardless of the model, the pharmacist should have direct care experience and pharmacist credentials are reviewed⁵⁻⁶
 - The pharmacist will be trained to access the patient's EHR and comprehensive care plan, and any network-specific workflows, as needed.
 -
- The pharmacist conducts the initial patient consult in person⁸.

³ Characteristics of patients with these needs could include patients with: multiple chronic conditions, complicated or multiple medication regimens, failure to achieve treatment goals, high risk for adverse reactions, preventable utilizations due to difficulty managing medication regimens (e.g. hospital admissions, readmissions, emergency department, urgent care, and/or physician office visits), health equity gaps, multiple providers, functional deficits (e.g. swallowing, vision, and mobility problems), and multiple care transitions

⁴ This assessment should occur at the time of the person-centered assessment for patients who are part of the CCIP Complex Care population. Other patients in need of additional medication management who are not part of CCIP can be identified/referred by other members of the care team or through automated triggers based on EHR-programmed "alert" claims or EHR-based analytic reports. The assessment should include patient preferences and concerns.

⁵ Possible models include: (1) pharmacist is a clinician staff member of the practice; (2) pharmacist is embedded in the practice site through a partnership between the practice and another entity (e.g., hospital, school of pharmacy, etc.); (3) regional model by which the pharmacist works for a health system and serves several practices in a geographic area; and (4) shared resource network model by which the pharmacist is contracted by a provider group, ACO, or payer to provide services to specific patients

⁸ For patients participating in the CCIP Complex Care program, this consult should occur in conjunction with the initial comprehensive care team person-centered assessment and/or care planning meeting, while other patients should schedule a consult with the pharmacist within a specified timeframe post-identification of the need for CMM. For less complex patients, Once a patient is making good progress toward meeting the goals of a medication action plan, or for less complex patients, telehealth or telephonic, or other touch points may be advisable.

3. Develop and implement a person-centered medication action plan

- The pharmacist develops an action plan during the initial patient consultation in partnership with the patient and/or caregivers
- To develop the person-centered medication action plan the pharmacist will:
 - Create a comprehensive list of all current medications the patient is taking including prescribed medications, nonprescription/over-the-counter medications, nutritional supplements, vitamins, and herbal products. Assess each medication for appropriateness, efficacy, safety, and adherence/ease of administration given a patient's medical condition and co-morbidities.
 - This assessment will be person-centered and also take into account the compatibility of medication with the individual's cultural traditions, personal preferences and values, home or family situation, social circumstances, age, functional deficits, health literacy, medication experiences and concerns, lifestyle, and financial concerns including affordability of medications compared to other regimens that achieve the same medical goals.
- The person-centered medication action plan includes:
 - An updated and reconciled medication list with information about medication use, allergies, and immunizations.
 - Education and self-management training to engage patients and their caregivers on better techniques to achieve self-management goals and adhere to the medication regimen..
 - The patient's treatment goals and pharmacist's actionable recommendations for avoiding medication errors and resolving inappropriate medication selection, omissions, duplications, sub-therapeutic or excessive dosages, drug interactions, adverse reactions and side effects, adherence problems, health literacy challenges, and regimens that are costly for the patient and/or health care system; pharmacist's recommendations are communicated to patients, caregivers, primary care provider, and other health care providers as needed.
 - An outline of the duration of the CMM intervention; frequency of interactions between pharmacist and patient throughout the CMM intervention; and instructions on follow-up with the pharmacist, comprehensive care team, primary care team, and specialists as needed⁹.
 - Coordination of care, including the referral or transition of the patient to another health care professional.
 -
- The person-centered medication action plan becomes a part of the patient's medical record
 - The network develops a process or protocol to make the person-centered medication plan accessible to all necessary care team members. The process or protocol will include:
 - Identifying who needs to have access to the person-centered medication action plan, which at a minimum will include the pharmacist

⁹ Patient with more complex needs may require more frequent follow-up with the pharmacist and care teams. The plan should identify the format for touch points, which should be guided by patient preference and the team needs assessment. Some formats include in-person, telephonic, and other telehealth mediums.

and primary care provider but which should also be guided by patient preference and the team needs assessment¹⁰.

- Developing technological capabilities for specified individuals to have access to the person-centered medication action plan

4. Follow-up and monitor the effectiveness of the medication action plan for the identified patient.

- Pharmacist monitors and evaluates the effectiveness of the care plan and modifies the plan in collaboration with other health care professionals and the patient or caregiver as needed. This process includes the continuous monitoring and evaluation of:
 - Medication appropriateness, effectiveness, and safety and patient adherence through available health data, biometric test results, and patient/caregiver/primary care provider feedback.
 - Clinical endpoints that contribute to the patient's overall health.
 - Outcomes of care, including progress toward or the achievement of goals of therapy.
- Schedule follow-up care as needed to achieve goals of therapy.
 - The pharmacist and care team initiate follow-up care processes to schedule touchpoints with the patient and/or caregiver as outlined in the person-centered medication action plan¹¹
 - The pharmacist participates in the comprehensive care team meetings if the patient is also participating in the CCIP complex patient intervention. The pharmacist and care team define a process to monitor and revise the person-centered medication action plan as necessary after follow up visits with the care team.

COMMENTER # 9

Page 3

The term whole person centered care is hyphenated differently in the document. I think you have latitude to choose whichever way you prefer (in documents outside of the SIM, I have seen person-centered, person centered, whole-person and whole person).

Most primary care practices are also part of a larger network of providers, which we call Advanced Networks. These Advanced Networks have organized to take responsibility for providing better quality care and lowering the cost of care by entering into value-based payment arrangements with Medicare and commercial health plans.

¹⁰ If the patient has a comprehensive care team or is working with a Community Health Worker, those individuals should also have access.

¹¹ Other care team members who are part of the implementation plan are identified through the consultation process. The touch points should align with those identified in the person-centered medication action plan for those patients who are participating in the CCIP complex care management intervention.

Primary care is the bedrock of our health care delivery system. Many primary care practices are working on improving their quality of care by becoming a medical home. They are putting into place new tools and care processes to provide more effective and better coordinated care. CT SIM developed the Advanced Medical Home Program as a way to help practices with the hard work that is required to become a medical home.

Page 4

clinical services is well recognized; research has shown that 60% of a patient's overall health status is influenced by social circumstances, behavioral choices, and environmental conditions, most of which lie outside the reach of our healthcare providers. This means that achieving Connecticut's healthcare goals will require identifying and addressing the non-clinical needs that contribute to poor health outcomes. A special emphasis will be placed on working with community partners, which are important for dealing effectively with environmental risks such as housing instability. This approach will make it possible to improve care for patients with complex care needs, reduce health equity gaps, and improve the overall care experience.

Page 5

- 1) Integrating behavioral health into primary care*
- 2) Integrating oral health into primary care*
- 3) Providing comprehensive medication management services*
- 4) Building dynamic clinical teams (note: this is later referred to as a comprehensive care team)*
- 5) Expanding e-consults between primary care providers and specialists*
- 6) Incorporating community health workers as health coaches and patient navigators*
- 7) Closing health equity gaps (through the ability to identify the gap using clinical data)*
- 8) Improving the care experience for vulnerable populations (using care experience data)*
- 9) Establishing community linkages with providers of social services, long term support services (LTSS), and preventive health*
- 10) Identifying patients with high needs for community care team interventions*
- 11) Producing actionable quality improvement reports*

Page 6

Comprehensive Care Management

Health Equity Improvement

Behavioral health

These core standards are designed to enhance competencies related to care management of individuals with complex needs³ with a focus on person-centered assessment; care plans that emphasize individual values, preferences and goals; the enhancement of the primary care teams

with additional clinical and community participants; and linkages with community-based services and supports.

Page 7

The text in the first box may be capitalized inconsistently plus spaces etc.

Supporting Individuals with Complex Needs
Comprehensive Care Team, Community Health Worker, Community Linkages

Page 11

This suggests that a patient with healthy behavior, supportive social circumstances, good living conditions, and access to routine preventive care has a better chance of experiencing positive health outcomes. Individuals with challenges in these areas face a greater risk of poor health and healthcare outcomes. Improving outcomes for individuals with significant non-clinical needs will require more than the provision of good clinical care within the clinical setting—it will require a more careful “person-centered” assessment and care plan combined with better integration of supportive clinical (e.g., behavioral and oral health) and non-clinical services (e.g., social services such as housing) into routine care. The proposed Core Standards are intended to promote care delivery reforms in these important areas.

Page 13, table 1

Spell out: Increased PCP visits and reduced ED and IP admissions (Health, 2014)

Page 15

The standards for CCIP will be included in the request for proposal (RFP) for the Medicaid Quality Improvement and Shared Savings Program (MQISSP). The Advanced Networks and FQHCs chosen to participate in the MQISSP will be required to meet the CCIP core program standards. They will be offered technical assistance provided by a vendor selected by the SIM PMO. Although participation in MQISSP is an eligibility requirement, the CCIP programs will be focused on improving care for all patients regardless of their insurance carrier (i.e.; payer).

Is this binding? What if the ANs and FQHCs decide to participate and then pull out if they decide they cannot reasonably meet the CCIP core program standards?

Page 20

In regard to the needs assessment and care plan and as we discussed in meetings, who is responsible for conducting the needs assessment and care plan? Will the primary provider really have adequate time? Will time be built in for these comprehensive interviews?

To design the standards for the health equity gap intervention, the PTF considered the following questions:

- 1. How will the network build the CHW workforce?*
- 2. How will the network identify patients who will benefit from more culturally attuned support?*
- 3. What will the care plan and needs assessment look like? And how will they be administered?*
- 4. How will the CHW successfully support the patient to meet the self-care management goals?*

A question or two to add might be: What are the funding sources for CHWs? Can they be mandated participants in the quality improvement process or on clinical teams without their services being reimbursable?

4. Conduct a person-centered needs assessment

□ To understand the historical and current challenges with self-care management to inform the person-centered self-care management plan, the network conducts a person-centered needs assessment that includes:

- o Preferred language*
- o Family/social/cultural characteristics*
- o Behaviors affecting health*
- o Assessment of health literacy*
- o Social determinant risks*
- o Personal preferences and values*

□ Network defines the process and protocols for the CHW to conduct the person-centered needs assessment⁴⁵

Is this saying the CHW conducts the needs assessment and goal setting for each patient? Is this in lieu of one done by the primary provider?

1. Identify individuals with behavioral health needs⁵³

□ The network develops a screening tool for behavioral health needs that is comprehensive and designed to identify a broad range of behavioral health needs at a minimum including:

- o Depression*
- o Anxiety*
- o Substance abuse*

o Trauma

I would recommend psychosis be included.

Page 40

In addressing behavioral health needs, function and resources are important factors for which to assess. Many people with moderate depression go to work and attend appointments. We are typically most concerned about individuals who cannot keep jobs, housing or appointments.

Page 55

1. How should networks identify complex patients?

Current programs use a variety of techniques to identify patients such as:

Physician referral

Individually selecting patients in the primary care or acute setting after displaying certain “warning signs”

I wonder if the first two (physician referral and self selecting) are fair. We will miss many people who may need it more. I would prefer we select individuals who meet a certain criteria. (usage of services, number of conditions etc.)

Page 61

2. How will the network identify patients who will benefit from more culturally attuned support?

Research trials tend to have two basic criteria for identifying eligible patients: (1) they belong to the sub-population that is experiencing a disparity (e.g., Latino, low-income, disabled, etc.) and (2) they have the clinical condition for which a disparity has been identified (e.g., type two diabetes with poor A1c control, high blood pressure, etc.) (Anderson AK, 2005) (Perez-Escamilla R, 2014) (The Institute for Clinical and Economic Review, 2013).

Stronger criteria are needed. Otherwise, I surmise many people will fall into this category.

Page 63-64

3. What type of relationship will be required between the primary care providers and the behavioral health providers to ensure that referral processes, protocols and expectations are met? SECOND DRAFT FOR DISCUSSION – 10-5-15

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The BHDG and the PTF recommends that the Advanced Network/FQHC execute at least one Memorandum of Understanding (MOU) with a behavioral health clinic and/or practice to promote accountability. Both providers are thus required to follow the MOU specified protocols and processes. The BHDG and PTF also recommends that processes and protocols are developed for referrals going to practices without an MOU as well.

I would also assume that the patient will have to sign a release of information or at least be advised of and sign an understanding of the MOU. This also assumes the person wants their behavioral healthcare at the designated clinic.