

CONNECTICUT HEALTHCARE INNOVATION PLAN



Connecticut State Innovation Model (SIM)

**Report of the Practice Transformation Taskforce on
Community and Clinical Integration Program Standards
for Advanced Networks and Federally Qualified Health Centers**

DRAFT FOR COMMENT

September 17, 2015

FIRST DRAFT

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Executive Summary

Connecticut's State Healthcare Innovation Plan (SHIP) articulates a vision to transform healthcare in the State. Connecticut seeks to establish a whole-person-centered healthcare system that improves population health and eliminates health inequities; ensures superior access, quality, and care experience; empowers individuals to actively participate in their healthcare; and improves affordability by reducing healthcare costs. In 2014 Connecticut received \$45 million grant from the Centers of Medicare & Medicaid Innovation (CMMI) to implement its State Innovation Model (SIM), which is the organizing vehicle through which programs in pursuit of this vision are developed, coordinated, and implemented.

Connecticut's SIM initiative emphasizes the importance of investing in care delivery transformation that improves care coordination, community linkages, whole-person centered care, and reduces health disparities. Care delivery transformation has to occur at multiple levels of the health care community. There is a need for practice level transformation that equips primary care providers with the tools necessary to provide advanced primary care as well as reform at the level of the organization, with which many practices today are affiliated. As part of its efforts to promote care delivery reform at the level of the organization, the SIM Test Grant is funding the launch of the **Clinical and Community Integration Program (CCIP)**. CCIP will support the advancement of health care organizations and their practices over the three year grant period (2016-2019).

CCIP seeks to support effective integration of both clinical and non-clinical services and to design a program to better integrate needed clinical and community services into the routine care of patients to improve overall access to high quality care, reduce equity gaps, improve care for patients with more complex care needs, and improve the overall care experience. The need within Connecticut – and nationwide – for better integration of community and 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 lies outside the reach of our healthcare institutions.

Under CCIP, Advanced Networks and FQHCs selected to participate in Medicaid Quality Improvement and Shared Savings Program (MQISSP) will be required to participate in SIM-funded technical assistance to coordinate to develop new capabilities for improving care, especially for at-risk populations. A special emphasis will be placed on working with community partners, which are so important for dealing effectively with environmental risks such as housing instability. Although only networks participating in MQISSP will be eligible for CCIP transformation support, the CCIP programs will focus on improving healthcare outcomes for all patients regardless of their insurance carrier (i.e., payer).

Development Process

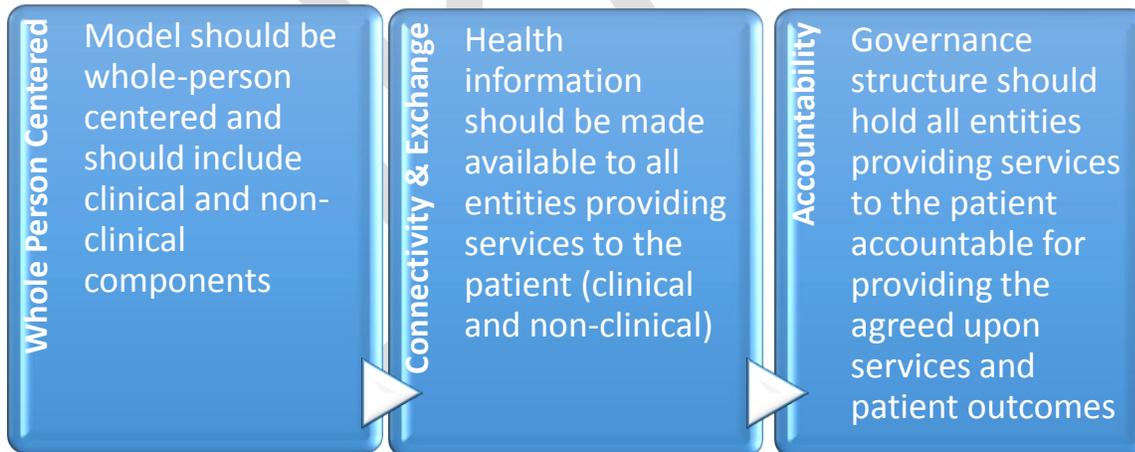
A Practice Transformation Task Force (PTTF) was established as part of the State Innovation Model Initiative and charged with recommending the design and standards for CCIP through a deliberative convening process of consumer, provider, payer, and government representatives. The PTTF began its work on CCIP standards by evaluating eleven capabilities that were identified in Connecticut's SIM Test Grant as part of the Community and Clinical Integration Program. These eleven capabilities included the following:

- 1) Integrating behavioral health into primary care
- 2) Integrating oral health into primary care
- 3) Providing medication therapy 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 (through the ability to identify poor care experience through data)
- 9) Establishing community linkages with providers of social services, long term support services (LTSS), and preventive health
- 10) Identifying “super-utilizers” for community care team interventions
- 11) Producing actionable quality improvement reports

Evaluation of these eleven capabilities included literature reviews, technical assistance from the Center of Medicare & Medicaid Services (CMS) and CMMI, input from subject matter experts, and counsel from Connecticut stakeholders working within these domains. All 11 capabilities were confirmed through this process to be included in the CCIP standards, but it was also confirmed that the capabilities needed to be integrated into a whole-person centered model of healthcare delivery.

Guiding Principles

To assist with the design of a model that suits Connecticut’s needs, the PTF analyzed the effective deployment of models in other parts of the country. Through this process the PTF developed three guiding principles for the design of the model:



Program Recommendations

CCIP will require participating entities to implement whole person-centered and supportive care management programs with a set of core and elective services. The core services include:

- Supporting Patients with Complex Needs (clinical and/or social)
- Reducing health equity gaps

- Integrating behavioral health

These core services encompass a broad range of care management, care coordination, and care transitions competencies incorporating community health workers to deliver more person-centered care and a better care experience. CCIP is also encouraging elective services, which include:

- E-consults
- Medication Therapy Management
- Oral Health

To accomplish the seamless integration of the various services networks will also need to establish community linkages through CCIP's requirement to establish local Community Health Boards.

Each service area has a corresponding set of program standards that are included in this report. Technical assistance will be provided by means of a transformation vendor who will assist participating organization from assessment to implementation of the core and elective capabilities.

Taken together the program standards represent a model that achieves these for principles and begins the process of integrating clinical and non-clinical services into a system of person-centered care. In recommending these standards, the PTF sought to balance the need for specific standards with the need for organizations to have the flexibility to innovate and also adapt the models according to local conditions and needs. Within each core and elective capability, standards have both required actions to be taken as well as suggested actions or references of successes in other markets across the country. It is the hope of the PTF that this model will provide primary care practices, Advanced Networks, and FQHCs the tools to expand this notion of comprehensive, person-centered care to their entire patient population.

1. Connecticut State Innovation Model Background

The State Innovation Model (SIM) program, administered by the Centers for Medicaid and Medicare Services (CMS), awards federal grants to states committed to developing and implementing multi-payer healthcare payment and service delivery model reforms that will improve health care system performance, increase the quality of care, and decrease costs.

In December 2013 Connecticut published its State Healthcare Innovation Plan (SHIP) in which it articulated a vision to transform healthcare in the State. Connecticut seeks to establish a whole-person-centered healthcare system that improves population health and eliminates health inequities; ensures superior access, quality, and care experience; empowers individuals to actively participate in their healthcare; and improves affordability by reducing healthcare costs.

SIM is the organizing vehicle through which programs in pursuit of this vision are developed and coordinated. In December 2014 Connecticut was awarded a \$45 million grant to begin working toward this vision over a four-year period (2015-2019). Connecticut's SIM initiative is comprised of a number of initiatives that include plans to improve population health, value based payment and insurance reform, quality measure alignment, health information technology, implementing a Medicaid Quality Improvement and Shared Savings Program, and primary care transformation.

Definitions:

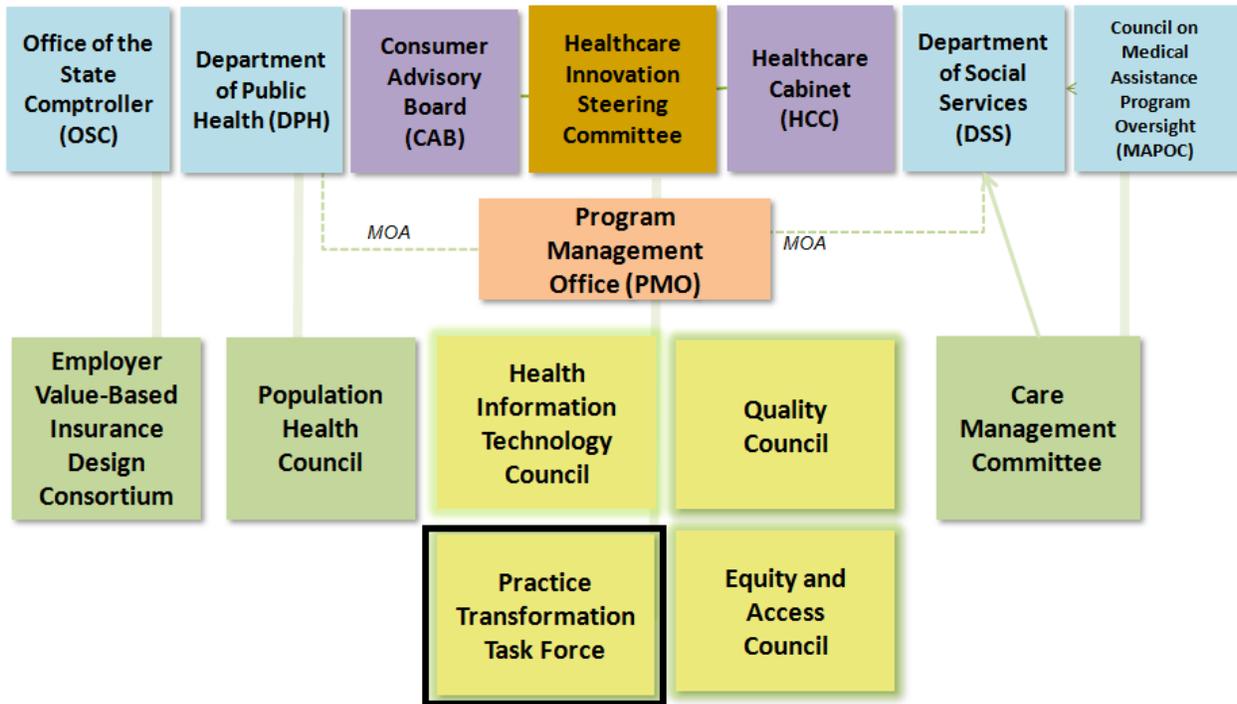
Person-Centered: The individual self-determines and identifies their natural supports, which may include but is not limited to family, clergy, friends and neighbors and chooses whether to involve them in their medical care planning. The individual actively makes all decisions about their care plan and treatment. Person-centered care focuses on the individual's values, belief, preferences, and needs, and ensures that these factors guide all clinical decisions as well as non-clinical decisions that support independence, recovery, and quality of life.

Value Based Payment: Forms of payment that hold providers accountable for the cost and quality of care they provide to patients. This differs from the more traditional fee for service payment method in which providers are paid for volume. The goal of value based payments is to replace inappropriate care with evidence-based, coordinated, and person-centered care and reward healthcare professionals and organizations for delivering value to patients. Examples of value based payments include shared savings programs (SSPs).

Shared Savings Program: A form of a value based payment that offers incentives to provider entities to reduce healthcare spending for a defined patient population by offering physicians a percentage of the net savings realized as a result of their efforts. Savings are typically calculated as the difference between actual and expected expenditures and then shared between payer and providers.

SIM initiatives will be informed by the recommendations of five work groups, including the work group responsible for generating the recommendations included in this report, the Practice Transformation Taskforce (PTTF) recommendations on the Community and Clinical Integration Programs (CCIP). In

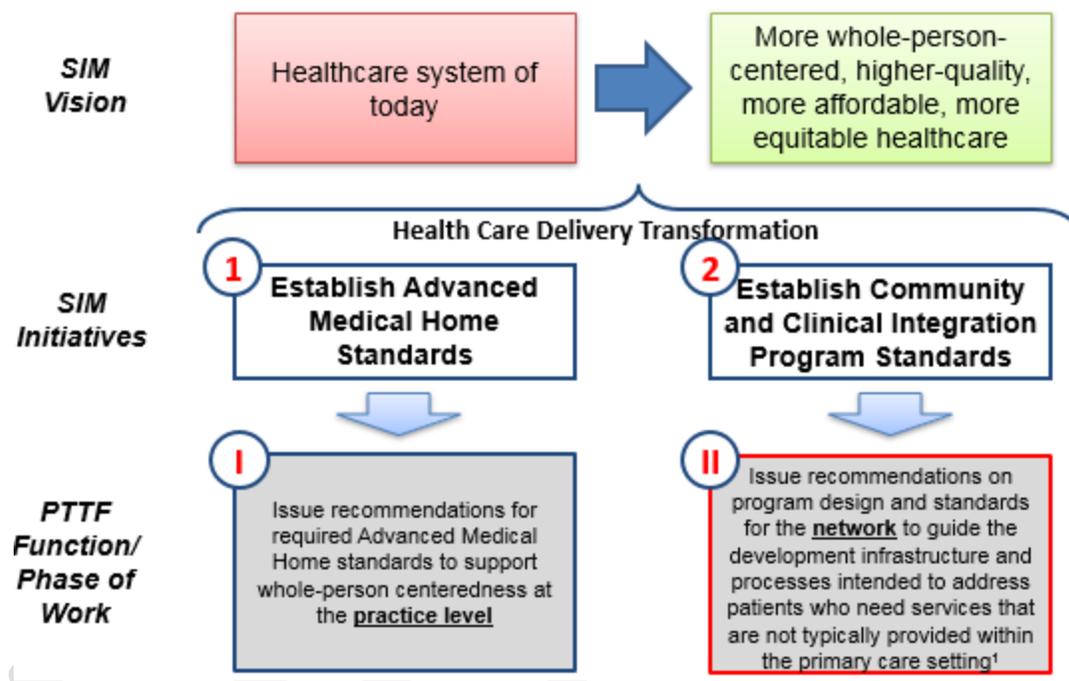
in addition to the PTF, there will be work groups on: Health Information Technology, Quality Alignment, Equity and Access, and Workforce Development. The work groups will be overseen by the SIM Project Management Office (PMO) with additional oversight from the Health Innovation Steering Committee and the Consumer Advisory Board, as depicted below.



2. The Practice Transformation Taskforce’s Role

An integral initiative of SIM is to change how care is delivered in the state to make it more whole-person centered. The Practice Transformation Taskforce (PTTF) was tasked with making recommendations on how to transform the delivery of care to be more whole-person centered at the practice level and at the network level.

To accomplish their work, the PTTF split their work into two phases. Within the first phase of work the PTTF was charged with developing Connecticut Advanced Medical Home standards. Within the second phase of work the PTTF was tasked with developing Community and Clinical Integration Program (CCIP) standards for Advanced Networks and Federally Qualified Health Centers (FQHCs).



Note: (1) This could include specialists outside the network (e.g.; behavioral health providers), clinically related support services (e.g.; pharmacists or dieticians), social support services (e.g.; housing or vocational assistance)

The need for developing the CCIP programs was born out of the growing recognition of the myriad factors outside of the clinical care provided that impact an individual’s overall health status. Research has shown that 60% of a patient’s overall health status is influenced by social circumstances, behavioral choices, and environmental conditions, while 10% is influenced by medical care and 30% by genetics (McGinnis JM, 2002). This suggests that a patient who partakes in healthy behaviors, has supportive social circumstances, and lives in good environmental conditions has a better chance of experiencing better health outcomes through seeking out routine clinical care. Improving outcomes of patients who have greater non-clinical needs will require more than the provision of good clinical care within the clinical setting. And, currently there is very little non-clinical needs being identified and non-clinical services being provided to these patients exacerbating poor health outcomes. Providing care for patients with non-clinical needs will require better integration of supportive clinical (e.g.; behavioral and oral health) and non-clinical services (e.g.; social services such as housing) into the routine care of patients. The objective of the CCIP is to make recommendations on the design of programs that

Advanced Networks and FQHCs can implement to support that integration and better meet the needs of patients who have clinical and non-clinical needs that cannot be addressed within the primary care setting.

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3. The Community and Clinical Integration Program (CCIP) Design and Implementation Approaches

CCIP Objective:

Improve overall access to high quality clinical care for complex patients (either due to clinical reasons, social reasons, or both) or patients experiencing a gap in their care and improving the overall care experience for the general patient population through improving clinical and community integration

CCIP Design

The PTF's task was to design a program to better integrate needed clinical and community services into the routine care of patients to improve overall access to high quality care, reduce equity gaps, improve care for patients with more complex care needs, and improve the overall care experience. To do this, the PTF sought to: 1) Gain a better understanding of the eleven capabilities set forth in the grant and their relative effectiveness; 2) Understand how programs across the country were addressing similar objectives; and 3) Evaluate how these capabilities could be most impactful for the residents of Connecticut.

The Connecticut SIM grant identified 11 capabilities that networks could implement to support better community and clinical integration. These 11 capabilities were stated as follows:

- 1) Integrating behavioral health into primary care
- 2) Integrating oral health into primary care
- 3) Providing medication therapy 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 (through the ability to identify poor care experience through data)
- 9) Establishing community linkages with providers of social services, long term support services (LTSS), and preventive health
- 10) Identifying "super-utilizers" for community care team interventions
- 11) Producing actionable quality improvement reports

To gain a better understanding of the capabilities and their effectiveness, how they were being applied across the country, and how they supported Connecticut's needs more specifically the council:

- Reviewed literature on the effectiveness of these capabilities

- Solicited Center for Medicaid and Medicare Innovation (CMMI) technical assistance¹
- Conducted a number of interviews (see Appendix C for full list) with subject matter experts and leadership teams running programs across the country that were intended to achieve similar objectives
- Received input from Connecticut Stakeholders (e.g.; The Primary Care Coalition of Connecticut)

The PTF’s evaluation of the individual capabilities concluded that each capability is an important element in supporting the objectives of CCIP.

#	Capability	Effectiveness
1	Behavioral Health	• Reduction in overall medical care and cost through better behavioral health integration into primary care (Community Health Network of Washington, 2013)
2	Oral Health	• Better treatment of periodontal disease can lead to improved outcomes and lower costs for other healthcare conditions (Qualis Health, 2015)
3	Medication Therapy Management	• Reduced medication and other health care utilization cost/claim and annual cost/patient; Improved patient satisfaction (Smith M, 2013)
4	E-Consults	• Timely access to medical care and reduced patient wait times for specialists appointments (UConn Health; Center for Public Health and Health Policy, 2014)
5	Community Health Worker	• Improved quality, healthy equity and costs (The Institute for Clinical and Economic Review, 2013)
6	Comprehensive Care Team	• Increased PCP visits and reduced ED and IP admissions (Health, 2014)
7	Community Linkages	• Crucial component of addressing complex patients and equity gaps (The Center for Health Care Strategies, Inc., 2014)
8	Identifying Equity Gaps	• Allows for design of equity gap interventions tailored to meet needs of patients experiencing the disparity (NCQA, 2014)
9	Identifying Super-Utilizers	• A number of innovative models across the country are currently being tested and while still early, some initially are showing positive outcomes – improved quality and lower cost (Health, 2014) (DiPietro, 2015)
10	Identifying Care Experience Opportunities	• Early super-utilizer program results are also showing improved patient experience (Health, 2014)
11	Actionable Quality Metrics	• Providing quality information can help pinpoint where improvements are needed (Halfon N, 2014)

While all the individual capabilities displayed positive attributes, the research on local and national models suggested that better integration of community and clinical needs was less about the individual capabilities and more about how the capabilities were utilized in conjunction with one another and who

¹ CMMI technical assistance is provided to all states participating in SIM to support grant implementation activities. The information provided often draws on best practices from other states participating in SIM.

(i.e.; which patients in particular) the capabilities were intended to support. PTF therefore focused on how to build a comprehensive model integrating these capabilities and ensuring supportive, person-centered care that suited patient needs across the care continuum. A core component of this model is streamlining communications across settings of care to improve care transitions through a central team

Definitions:

Super Utilizer: Individuals whose complex physical, behavioral, and social needs are not well met through the current fragmented health care system. As a result, these individuals often bounce from emergency department to emergency department, from inpatient admission to readmissions or institutionalization – all costly, chaotic, and ineffective ways provide care and improve patient outcomes (Robert Wood Johnson, 2013)

Medicaid Health Homes: An optional Medicaid state plan benefit for states to establish Health Homes to coordinate care for people with Medicaid who have chronic conditions...CMS expects states health home providers to operate under a “whole-person” philosophy. Health home providers will integrate and coordinate all primary, acute, behavioral health, and long-term services and supports to treat the whole person (Medicaid, 2015)

capable of managing the entire care experience. It should be noted that the PTF changed the name of the dynamic clinical care team to a comprehensive care team to more accurately describe the purpose of the team as reflected in the literature.

To inform the design process for CCIP, the PTF considered several models across the country with the similar objective of transforming how health care is delivered to better address the non-clinical determinants of health (i.e.; social and environmental circumstance and behavioral choices). The Center for Health Care Strategies, Inc. examined programs intended to address the needs of “super-utilizers” across 26 states, many of which use the Medicaid Health Home model as a basis for creating these programs. While the Medicaid Health Home model is commonly used, there are some programs that have been developed locally due to an identified need (Center for Health Care Strategies, Inc., 2015). Early adopters of Medicaid Health Homes include Iowa, Missouri, New York, North Carolina, Oregon, and Rhode Island. The most well-known examples of locally developed solutions are the Camden Coalition and Hennepin County (Center for Health Care Strategies, Inc., 2015) (Coalition, 2015) (Health, 2014) (The Center for Health Care Strategies, Inc., 2014).

The early adopters of the Medicaid Health Homes and other programs such as the Camden Coalition and Hennepin County revealed the following design choices to be the most effective:

#	Design Feature	Examples
1	Careful definition of the target population	<ul style="list-style-type: none"> • NY Health Home: Intensive care management to “high-need” individuals • Rhode Island Health Home: Adult behavioral health needs
2	Design of services to meet the needs of the target population	<ul style="list-style-type: none"> • Hennepin: care team supporting patient is determined based on risk assessment • Multiple Health Homes: identify care team members to meet with patient face-to-face in the home to better suit their needs
3	Real time access to data that supports effective care coordination	<ul style="list-style-type: none"> • Camden Coalition and Hennepin: Local health information exchange that includes data from all local health care providers and is made available to all relevant care team members • New York Health Home: have to meet state established technology standards • Multiple Health Homes: methods to alert health homes about admissions and discharges from hospitals and EDs
4	Accountability for services provided with community-based organizations	<ul style="list-style-type: none"> • Multiple Health Homes: set clear performance requirements and provide support to meet those requirements • Camden Coalition: scorecard reviewed with care team on monthly basis to identify opportunities for improvement
5	Support provided to achieve cultural change	<ul style="list-style-type: none"> • Iowa Health Home: care clinician role intended to support health homes transform how they deliver care to be a health home

Reference: (Coalition, 2015) (The Center for Health Care Strategies, Inc., 2014) (Health, 2014)

Beyond the framework of the model, early adopters noted that flexibility within the Health Home implementation guidelines to tailor the design and reimbursement of services to meet their respective local needs was an important success factor.

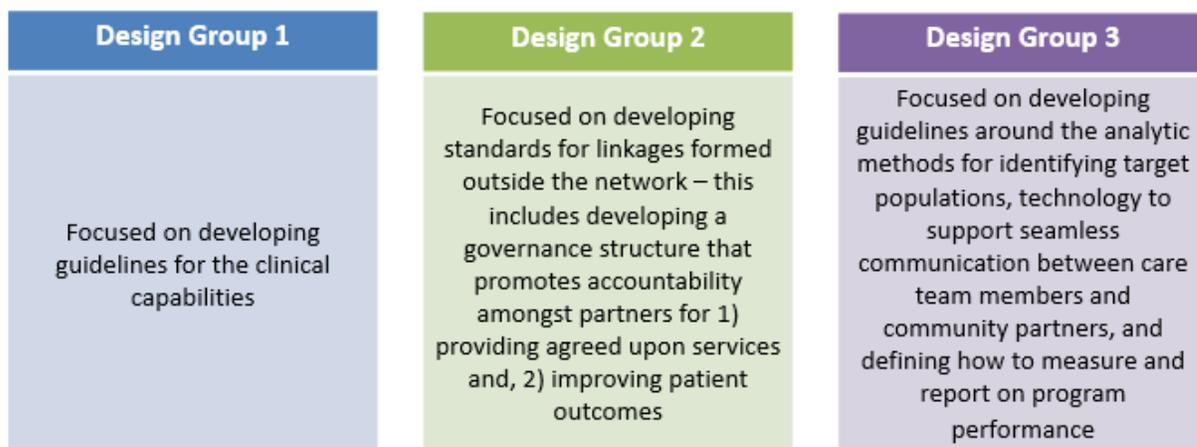
The PTF’s review of program design features of the programs across the country suggested that there should be three design guiding principles for CCIP in Connecticut:

- 1 Model should be whole-person centered and include clinical and community components**
 - Clinical and non-clinical support services should be brought to the patient
 - Care team structure should reflect the needs of the patient
- 2 Health information should be made available to all entities providing services to the patient (clinical and non-clinical)**
- 3 Governance structure should hold all entities providing services to the patient accountable for providing the agreed upon services and patient outcomes**

To fulfill the design guiding principles the PTF used the following design approach:

1. Identify target populations considering the objectives of SIM, CCIP, and the broader needs of Connecticut;
2. Define which program capabilities would be core to addressing the needs of these target populations and which would be elective;
3. Design programs at a high level; and
4. Develop standards for networks to implement these programs.

The entire taskforce first determined the target populations and the associated core vs. elective capabilities before splitting into smaller design groups to concentrate focus and expertise around certain model components. Specifically, the design groups addressed the detailed design elements of the capabilities needed to address the needs of each target population (high level program design and standards). PTF divided this phase of the process into the following design groups:



The design groups reviewed program design options and standards in more detail. Their discussions and points of view were brought back to the entire PTF for discussion to finalize the set of recommendations for standards being put forth for each target population. PTF members were assigned to different design groups based on their backgrounds and expertise and were asked to attend and participate in two design sessions throughout the process. All design groups were open to all PTF members and the public. The PTF’s schedule from April through October 2015 was as follows:

WORKSTREAM/ACTIVITY	April			May			June			July			August			September			October												
	30	6	13	20	27	4	11	18	25	1	8	15	22	29	6	13	20	27	3	10	17	24	31	7	14	21	28	5	12	19	26
Practice Transformation Taskforce (CCIP)																															
Practice Transformation Taskforce Meetings		7			28			19			9			30				28													
Practice Transformation Taskforce Executive Team Meetings									2			23					21														
Design Group 1							26							16																	
Design Group 2							27										6														
Design Group 3										1																					
Healthcare Innovation Steering Committee (HISC)																															

As design group two progressed in their discussions, members concluded that networks should be developing standards for community linkages to serve all patients rather than specific standards for each target population. The design group therefore sought to create standards at the network level for Advanced Networks and FQHCs to work with the communities on those protocols and processes. To accomplish this, design group members advised the development of a Community Health Board collaborative comprised of local stakeholders that would be tasked with developing protocols for better integration of shared resources into the provision of healthcare services. Therefore, in addition to the core standards around CCIP interventions for specific target populations, there will also be core standards developed for Advanced Networks and FQHCs to establish these local collaborative efforts.

The standards for CCIP will be incorporated into the request for proposal (RFP) for the Medicaid Quality Improvement and Shared Savings Program (MQISSP) as a requirement for Advanced Networks and Federally Qualified Health Centers (FQHCs) participating in MQISSP. The standards have also been reviewed by the Council on Medical Assistance Program Oversight Care Management Committee (MAPOC CMC) which has oversight of Connecticut’s Medicaid program.²

CCIP Implementation Approach

The Advanced Networks and FQHCs chosen to participate in the MQISSP will be required to meet the CCIP core program standards in delivering patient care. They will receive Technical Assistance provided by a vendor selected by the SIM Program Management Office (PMO). Although only networks participating in MQISSP will be eligible for CCIP development support, the CCIP programs will be made available to all patients regardless of their insurance carrier (i.e.; payer) or insurance status (i.e.; the insured and uninsured).

The vendor will have two roles: 1) to assist the network in conducting a needs assessment to confirm that CCIP core interventions align with network needs³; and 2) to assist the network with a gap analysis to inform an implementation plan for the CCIP intervention. The plan will include an assessment of which standards are not being fulfilled and identifying what will be needed to implement them going forward.

Additionally, the vendor will have to make an assessment about the feasibility of the network to fulfill the core intervention standards over the 18 month support period based on the current state of the

² The MAPOC is a, “collaborative body consisting of legislators, Medicaid consumers, advocates, health care providers, insurers and state agencies to advise DSS on the development of Connecticut’s Medicaid Managed Care program and for legislative and public input to monitor the implementation of the program” (Council on Medical Assistance Program Oversight, 2015).

³ If the standards do not align with network needs, the vendor will work with the AN/FQHC to determine how to adapt the core interventions and/or include the elective interventions to better meet their network’s population needs;

network capabilities. If it is determined by the vendor that it will not be possible to fulfill all core interventions over the 18 months, the vendor will prioritize which intervention standards will be implemented first, based on the needs of the network's population.

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4. CCIP Target Population Definitions

Whole-person centeredness has been a foremost consideration in the design of CCIP. As evidenced by the examples of similar state and national model programs, designing programs around a specified target population promotes whole-person centeredness because the design reflects the identified needs of the patients. While many sub-populations within Connecticut can be identified, the PTF sought to target certain populations that had a demonstrated need for improved care manifested by unnecessary and/or inappropriate health care utilization, poorer health outcomes, or often a combination of both (The Center for Health Care Strategies, Inc., 2014) (Center for Health Care Strategies, Inc., 2015).

Recognizing the importance of this approach, the PTF strove to make recommendations that balanced the ability to tailor network approaches to meet the needs of their patients while also having a level of standardization across networks in how the CCIP programs are implemented. The PTF agreed that CCIP should be designed around pre-determined target populations while allowing for flexibility amongst the networks to more specifically define the targeted population to meet the specific needs of patients attributed to their networks. The PTF explored the objectives of CT SIM and the needs of the state more broadly to help identify the most appropriate target populations for Advanced Networks and FQHCs.

To define target populations for CCIP the PTF considered the following criteria:

#	Design Consideration	Why Is This Important?
1	Alignment with stated SIM goals	<ul style="list-style-type: none"> Financially aligns CCIP with shared savings programs to facilitate future integration of efforts
2	Alignment with needs of Connecticut	<ul style="list-style-type: none"> Positions CCIP to advance Connecticut's population health goals while remaining payer agnostic
3	Standardization balanced with implementation flexibility	<ul style="list-style-type: none"> Ensures some level of consistency in how CCIP is implemented across networks Promotes whole-person centeredness

Based on the above considerations, three target populations were identified that met the population health needs of Connecticut while achieving SIM goals and providing the right balance between standardization and local innovation: complex patients, patients experiencing equity gaps, and patients with unidentified behavioral health needs. The definitions for these populations are as follows:

Complex Patients: Patients who have either multiple complex medical conditions, multiple detrimental social determinants of health, or a combination of both that contribute to preventable service utilization and poorer overall healthcare management that ultimately negatively impacts the patient's overall health status

Patients Experiencing Equity Gaps: Patients belonging to a sub-population experiencing poorer health outcomes in a specific clinical area (e.g.; diabetes). For the first wave of CCIP, the intervention will focus on sub-populations defined by large race and ethnic populations, specifically White, Black, and Latino. The intervention will further target diabetes, hypertension, and asthma, as these conditions are included in the SIM Provisional Core Quality Measure set.

Patients with Unidentified Behavioral Health Needs: Any patient with an unidentified behavioral health need including mental health, substance abuse, or history of trauma.

The table below provides a summary of how these target populations meet the outlined design considerations:

Target Populations:	Complex	Equity Gaps	Behavioral Health
<p>Alignment with CT SIM and CCIP</p>	<ul style="list-style-type: none"> • Reduce readmissions and ASC admissions • Reduce ED use 	<ul style="list-style-type: none"> • Reduce health equity gaps 	<ul style="list-style-type: none"> • PCMH CAHPS behavioral health access • Behavioral health screening/depression remission
<p>Alignment with CT Needs</p>	<ul style="list-style-type: none"> • Plans in state to develop specialized interventions in Medicaid for individuals with most complex needs • Absence of programs to address complex needs for broader patient population 	<ul style="list-style-type: none"> • Known gaps in care in the state along racial and ethnic lines (Connecticut Healthcare Innovation Plan, 2013) 	<ul style="list-style-type: none"> • 2013 OHA report on access to mental health identified deficits in routine recognition of mental health needs and access to services (Connecticut Office of the Healthcare Advocate, 2013) • Work underway to develop behavioral health homes targeted at individuals with severe and persistent mental illness
<p>Flexibility</p>	<ul style="list-style-type: none"> • Networks will be able to define more specifically what complex means within their patient population • For example, networks can create a risk stratification that identifies complex patients within their network population 	<ul style="list-style-type: none"> • The equity gaps will be defined to align with the equity gaps tracked on the quality scorecard • Within what is tracked, networks will do an initial assessment to determine which area is most applicable amongst their patient population 	<ul style="list-style-type: none"> • Basic standards around the process to routinely screen and refer patients for behavioral health needs will be developed • Screening tools can be adapted/defined based on the BH needs viewed to be most prevalent amongst their patient population

5. CCIP Detailed Intervention Design: Core and Elective Interventions

Core Interventions for Target Populations

Complex Patients

Many of the innovative models around the country broadly target the needs of patients who are considered to be complex, often referred to as “super-utilizer” programs (The Center for Health Care Strategies, Inc., 2014). Although none of the programs reviewed are exactly the same, most use the same basic intensive care management design structure. 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 care management teams is to focus on in-person care management and the integration of care between primary care providers and community resources in order to comprehensively support the individual and address their clinical and non-clinical needs. The common tools used by these teams include needs assessments and person-centered care plans. The needs assessments are used to identify the clinical, social, and behavioral needs most relevant to the individual. A person-centered care plan supports the patient in achieving their care goals by ensuring transparency, portability, and continuity of the patient’s medical condition and personal preferences and goals (Spencer A, 2015) (Samuelson, 2015) (Hawthorne, 2015) (Health, 2014). At a high level the following program design is commonly used:

1. Identify target population;
2. Connect the individual to a comprehensive care team⁴ charged with providing intensive care management;
3. Conduct a person-centered (see Appendix A for definition) needs assessment that informs a person-centered care coordination plan, both of which are predominately focused on the identified individual’s non-clinical (i.e.; social and behavioral) needs;
4. Execute the care plan, provides updates to the primary care team, connects the individual to needed clinical and non-clinical services, and supports the individual to transition to more self-directed care management; and
5. Track the individual and reconnects with the individual if needed.

To design standards for how Connecticut Advanced Networks and FQHCs should implement a similar program to meet the needs of complex patients in their network, the PTF discussed a set of design questions that informed the creation of the standards being put forth. The main design questions posed were:

1. How should networks identify complex patients?
2. Who will the core members of the comprehensive care team be? And, what will their roles be?
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? And, how will they be administered?
6. How will the comprehensive care team support the patient to successfully meet the care plan goals?

⁴ Programs use multiple names for their care management teams, including: community care teams, integrated care delivery teams, community health teams, etc. Comprehensive Care Team is the name the PTF felt was appropriate for the CT CCIP Complex Patient Intervention.

7. What mechanism can the networks use to monitor individual health status post-transition to self-directed care management?
8. How will the networks monitor the effectiveness of the intensive care management intervention?

To answer these design questions the group considered the best practices emerging from other similar programs and drew on their individual expertise and experiences as providers, payers, and consumers of healthcare in Connecticut.

1. How should networks identify complex patients?

Current programs display a range of techniques to identify patients from physician referral to manual selection to basic analytics to conduct risk stratification to advanced analytics to do predictive modeling (Depriest A, 2015) (see Appendix A for definitions). Regardless of the method used, the most important element in identifying complex patients is to take into consideration utilization as well clinical, social, and behavioral risk factors.

The PTF felt that the best option is to use predictive analytics where possible while recognizing that it is likely that many of the Advanced Networks and FQHCs in Connecticut do not have that capability today. However, networks will have access to claims data through Medicaid and private payers. As such, networks will be able to do utilization-based risk stratification. Taking this into consideration, the PTF determined that the networks should use basic analytics to do risk stratification that accounts for utilization accounting for clinical, social, and behavioral risk factors while attempting to move toward more advanced predictive analytics as technology and capacity allow.

2. Who will the core members of the comprehensive care team be? And, what will their roles be?

The care management teams across different programs are all tailored to meet the specific needs of their patients. For this reason, these teams all have slightly different members. However, there are core roles common across most teams that include: a case manager, a clinically focused care coordinator, and a community focused care coordinator who connects individuals to needed social services and provides culturally and linguistically aligned self-care management education. Additionally, most teams have a care team manager who oversees the team's activities and integration into the primary care team. While the above roles are common features of all teams, teams also have additional members as needed that reflect the specific needs of the individual patients (Spencer A, 2015) (Takach M, 2013).

The PTF agreed that these roles should be core to the CCIP complex patient intervention and that the initial needs assessment of their complex patient population should be used to inform whether additional team members/functions should be added and/or made available when needed (e.g.; a pharmacist or dietician). Additionally given the common occurrence of behavioral health needs amongst complex patients (Brown D, 2014), the PTF felt strongly that the team should either have a team member who is also a licensed behavioral health care specialist or at a minimum timely access to a licensed behavioral health care specialist.

Aside from the behavioral health specialist, the PTF elected not to require specific credentials for any of the care team members. The PTF acknowledged that many networks have employees today that fulfill case management and care coordination roles and that these roles are filled by individuals of

varied credentials according to the local needs of the patient population. To allow for networks to repurpose current employees to fulfill the CCIP requirements, the PTF decided that the care management, care coordination, and overall management function can be fulfilled by any individual with training in that area. However, the PTF will not require that the individuals have a specified set of credentials. Given the unique role of the Community Health Worker (CHW, see Appendix A for definition) in supporting the non-clinical needs of patients and the importance of this to the objectives of CCIP, it will be the only function that has to be fulfilled by a designated individual. To make sure there is clarity amongst all team members about each of their roles and responsibilities on this team, the Advanced Network and FQHC will have to develop written job descriptions outlining how each member will fulfill their specified function.

3. How will the network build the comprehensive care team workforce?

The Advanced Networks and FQHCs will likely fall along a spectrum of readiness to create a comprehensive care team. Some networks will already have the staff resources for a comprehensive care team in place or all the necessary functions fulfilled, but these teams may be organized differently around the patient. The networks will also vary in structure. Some networks will be fully vertically integrated with other health care entities (e.g.; a hospital) while others will be a collection of physician practices. Given the variations in structure between networks and the state of readiness of networks to build a comprehensive care team, the Taskforce agreed that the strategy chosen to build the comprehensive care teams and how they are operationalized in practice should be decided by the networks. The community health worker will be the one key comprehensive care team member that the networks are less likely to have today, thus requiring the network to decide whether to employ CHWs or contract with an organization to provide CHW services. The PTF felt that the decision as to whether to employ or contract should be left up to the network. Regardless of this decision, the key responsibilities of the community health worker should be made explicitly clear. Similarly, in order to ensure effectiveness of the comprehensive care teams, the PTF also encourages networks to determine the caseload that a comprehensive care team can manage. Determining the case load for the comprehensive care team will support developing a strategy and operational plan that is most efficient for the network.

4. What type of training will comprehensive care teams and primary care practices require?

Existing programs focus training on team-based care and the associated work-flow redesign. The addition of a comprehensive care team into the primary care setting to provide intensive care management will either introduce new positions that did not previously exist into the care setting or re-define existing team member's scope of work. An effective comprehensive care team will need to be appropriately integrated into the primary care practice through re-designed workflows and practice-wide understanding and support of the values, principles, and goals of the comprehensive care team's work (Spencer A, 2015).

The only team member with more specific training needs is the community health worker. A community health worker is defined as a "frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served" (American Public Health Association, 2015). CHWs play a unique role building trusting relationships with individuals with whom they work, connecting the individuals to needed services, and providing culturally and linguistically aligned self-care management education. CHWs are generally provided training to do this, which includes: tools to build

trusting relationships, how to identify patient behavioral and social needs and connect individuals to relevant supportive services, the provision of health education to support behavior change, and how to advocate on behalf of the individuals whom they support (Boston, 2007).

The PTF felt that better integrating primary care with community care through the use of a comprehensive care team is a large paradigm shift for primary care practices. Team based training that supports this shift and clarifies roles and responsibilities for all care providers in the new care model should be required. In addition, the PTF agreed that, since Connecticut does not currently have CHW credentialing or certification networks, it will be required that all CHWs are appropriately trained, as defined by the network, to provide the needed support to patients.

The PTF also pointed to the fact that many complex patients will have behavioral health needs and represent a variety of cultural backgrounds. Given this the PTF also wanted to require that members of the comprehensive care team have basic behavioral health training and meet culturally and linguistically appropriate care delivery standards. The technical assistance vendor can assist networks with identifying appropriate training programs and processes for networks.

5. What will the needs assessment and care plan look like? And, how will they be administered?

Needs assessments across programs varied from being as simple as a brief intake form (Coalition, 2015) to involving complex eco-mapping to provide historical context on the patient's needs including the use of previous patient medical records and claims data to gain a better understanding of past healthcare utilization (Samuelson, 2015) (Spencer A, 2015). Regardless of the historical depth of the needs assessments, they generally cover clinical/physical, behavioral, and social needs and take into consideration the individual's cultural characteristics and linguistic needs (Spencer A, 2015). Person-centered care plans are driven by a patient's and their natural supports' (see Appendix A for definition) input, if desired, and address needs highlighted in the needs assessment. Care plans commonly articulate clear goals, who on the care team is responsible for supporting the patient to meet those goals, and timeframes for achieving the stated goals (Coalition, 2015) (Kansas Medicaid, 2015). And, in contrast to the primary care practice plan, the person-centered care plan is intended to be owned and carried out by the comprehensive care team with a focus on addressing the individual's non-clinical needs (Hawthorne, 2015) (Samuelson, 2015). Since many of the intensive care management programs are person-centered, the creation of the needs assessment and care plan, as well as who is involved in the process of creating them, is largely dependent on what is most convenient for and preferred by the individual and their natural supports.

The PTF agreed that the needs assessment should draw on historical and current needs as well as a care plan that clearly articulates goals and timeframes within which to reach those goals. However, the PTF was primarily concerned that the standards around the needs assessment and care plan be person-centered. Thus, in addition to recommending standards for needs assessments and care plans in line with other programs, the PTF also articulates standards for how the Advanced Networks and FQHCs can ensure person-centered orientation of the needs assessments and care plans. Additionally, to clarify that the care plan is distinct from the primary care generated care plan, the PTF agreed that the name of the care plan should represent its purpose and chose to refer to the care plan as a care coordination plan.

6. How will the comprehensive care team support the individual to successfully meet the care plan goals?

Some care teams managing individuals have defined schedules for checking in with the patient as well as mechanisms to connect with individuals outside the set schedule when additional support is needed (Coalition, 2015). Meanwhile, others frequently check in with patients in a less rigid manner on an as needed basis to support carrying out the care plan (Takach M, 2013) (DiPietro, 2015). The most crucial components to successful coordination of an individual's care are the regular monitoring of care plan progress and frequent communication through the seamless exchange of necessary healthcare information. It is important that the monitoring and exchange of information occur at several levels: 1) between the health care providers/care management team and the individual and their families in regards to their care plan; 2) within the health care and care management team and needed social support services; and, 3) across the entire care spectrum to help support transitions of care (Agency for Healthcare Research and Quality, 2012). This in part is facilitated by frequent check-ins with the patient to monitor their progress, but also by technology solutions that can support the seamless communication of pertinent healthcare information between the care teams and across the healthcare continuum. Beyond the technology to support seamless communication and connections to social services, an integral part of many programs is the development of more formal healthcare linkages to community based social support services (Takach M, 2013) (The Center for Health Care Strategies, Inc., 2014).

The PTF felt that it would be important that teams establish pre-determined check-ins with individuals to monitor progress on their care coordination plans as well as have mechanisms to support individuals outside of the pre-determined schedule (e.g.; establish processes for the individual to reach out when support is needed and technology solutions to alert the team when an individual is in the hospital or emergency department and may need additional care team support). Additionally the PTF felt it was crucial that standards were established to support seamless communication through technology and for the networks to create linkages to community resources. However, the PTF also acknowledged that networks would likely have different needs and preferences in regards to technology solutions and thus did not specify a technology solution as part of the standards. The PTF also decided that establishing better integration of shared community resources was of utmost importance to the CCIP interventions and felt it should happen at a broader network level, not only in relation to the target populations (see section Community Consensus & Linkages for Community Health Board standards)

7. What mechanism can the networks use to monitor individual health status post-transition to self-directed care management?

Many of the programs reviewed did not have specific mechanisms in place to do monitor individuals post-transition. However, if care management teams were alerted to an individual in crisis either through the individual reaching out or via statewide technology (e.g.; an admission discharge and transfer system – see Appendix A for definition), then there would at least be a mechanism for the care team to reconnect with the patient (DiPietro, 2015) (Lessler, 2014).

While it is uncommon for programs to have robust mechanisms around these types of alerts, the PTF felt it was important to provide guidance on how to monitor individuals and reconnect them with the comprehensive care team when necessary. Other programs suggested that it is important for the individual to reconnect with a known member of the care team when an individual does resume care

(Samuelson, 2015). Given this the PTF suggested that the network work with Peer Support specialists (see Appendix A for definition) to support individual transitions and be a point of contact if there is a need to reconnect to the comprehensive care team. In addition, the networks will be required to develop standards around monitoring mechanisms for transitioned individuals so the team can be alerted that an individual may be in crisis to ensure continuity of care and communication across providers.

8. How will the networks monitor the effectiveness of the intensive care management intervention?

The monitoring of effectiveness of intensive care management programs has been difficult because the care teams are often embedded in broader programs. For example, Vermont's Blueprint for Health recently compared outcomes of different primary care practices between practices with Community Health Teams (CHT), Vermont's version of a comprehensive care team, and practices without a Community Health Team to assess its effectiveness, but it could not necessarily attribute the improved outcomes to the CHT. However, Vermont is currently working on ways to link their clinical and claims data to be able to analyze performance specific to patients working with the CHTs. Other programs have used a number of process metrics to monitor performance (e.g.; number of patient contacts with community care team) and outcome metrics such as ED and hospital utilization pre/post community care team intervention (Depriest A, 2015).

The PTF felt that monitoring the effectiveness of the CCIP interventions, not just for complex patients, should incorporate both an assessment of overall effectiveness of the interventions as well as monitoring for process improvement through tracking intervention specific process metrics.

In addition, to hold individuals responsible for carrying out interventions accountable for meeting the specified goals, the PTF recommends standards around reporting on performance and providing a forum to share performance with relevant care providers to identify opportunities for improvement. In particular the PTF felt that learning collaboratives across practices could be useful and has shown to be effective in other programs, such as the Camden Coalition, for identifying improvement opportunities.

Patients Experiencing Equity Gaps

It is well known that there are disparities in outcomes for patients across certain sub-populations in Connecticut. As detailed in the Connecticut SHIP, Connecticut is one of the most racially, ethnically, and culturally diverse states in the country. However, the State currently does not perform well on population health and quality measures when outcomes are compared by race, ethnicity, geography, and income (Connecticut Healthcare Innovation Plan, 2013).

Acknowledgement of health care disparities in care has led national organizations like the NCQA to incorporate standards into their Accountable Care Organization (ACO) accreditation guidelines for how ACOs should develop continuous quality improvement methods targeting health disparities. While the NCQA provides standards around how to routinely identify disparities, how to prioritize which disparities to address and requires an intervention to be designed, and for the intervention to be monitored for its effectiveness, there are no standards provided for specific interventions (NCQA, 2014).

The PTF felt that establishing Connecticut-specific standards for Advanced Networks and FQHCs to do continuous equity gap improvement was important and would require networks to establish the analytic capabilities to routinely identify disparities in care, conduct root cause analyses to identify the best

interventions to address the identified disparities, and develop the capabilities to monitor the effectiveness of the interventions. For the initial purposes of CCIP, the standards are focused on identifying equity gaps across sub-populations defined by larger race and ethnic groups (White, Black, and Latino) and further limiting the assessment to identify gaps in outcomes for diabetes, hypertension, and asthma. The sub-populations are recommended for statistical reasons to ensure large enough comparison populations to show statistical differences, while the health outcomes recommended will be aligned with the SIM Core Quality Measure Set. While the initial recommendation is to identify disparities across specific sub-populations for a specific set of health outcomes, the Advanced Networks and FQHCs will attain the skill set and technology required to routinely identify and address disparities (for full standards see: Health Equity: Continuous Quality Improvement Standards at the end of this section).

While the continuous equity gap improvement standards require a root cause analysis, the PTF went a step further than NCQA and embarked on recommending standards for utilizing the support of a community health worker (CHW) to address equity gaps, which research has shown to be effective (Perez-Escamilla R, 2014) (Honigfeld L, 2012) (Anderson AK, 2005). If the root cause analysis reveals that the CCIP identified intervention is not the best course of action, the networks will have the opportunity to design their own intervention with the assistance of the technical assistance vendor.

To develop standards for a specific health equity gap intervention, the PTF considered the integration of a community health worker into the primary care setting to provide more culturally and linguistically appropriate care. Often gaps in care arise from language barriers and challenges with the cultural competency of providers and cultural gaps in patient education, in particular for patients with chronic illnesses that often have lifestyle components as part of the treatment (Perez-Escamilla R, 2014). Research on the use of community health workers to address gaps has been demonstrated to be very effective (Anderson AK, 2005) (Perez-Escamilla R, 2014) (The Institute for Clinical and Economic Review, 2013). In particular the use of CHWs has been shown to be effective in addressing diabetes, asthma, and hypertension, which aligns with the focus of the CCIP target population definitions (The Institute for Clinical and Economic Review, 2013).

In the studies that show effective results, the CHWs are usually representative of the population they are supporting by either being from the community or ethnically/racially and culturally similar to the patients. The interventions carried out by the CHWs are intended to promote patient education and self-care management through providing culturally and linguistically sensitive patient education, connecting the patient to needed community resources, acting as a liaison/representative of the patient's needs in the clinical setting, and empowering the patient to manage their own care based on the clinical guidance provided by their physician (The Institute for Clinical and Economic Review, 2013).

Similar to the complex patient population, establishing meaningful connections and relationships with community organizations to be able to offer needed services at the network level can help facilitate the supportive role of the community health worker. While there are similarities to the roles CHWs play when addressing equity gaps versus complex patients, the role of the CHW to address equity gaps is distinct in the emphasis placed on patient education and behavior change around the specific equity gap being addressed. The training of CHWs to address equity gaps will include a component regarding disease state specific culturally and linguistically appropriate education.

Programs and randomized control trials that utilize CHWs to address equity gaps follow a similar intervention approach to the intervention for complex patients:

1. Create a more culturally and linguistically sensitive environment
2. Establish a CHW workforce
3. Identify individuals who will benefit from the culturally attuned supportive services of a CHW
4. Conduct a person-centered needs assessment
5. Create a person-centered self-care management plan
6. Execute and monitor the person-centered self-care management plan
7. Identify when an individual is ready to transition to self-directed maintenance

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

As with the complex individual intervention, the group considered the best practices emerging from other CHW programs and research trials and drew on their individual expertise and experiences as providers, payers, and consumers of healthcare in Connecticut to answer these design questions.

1. How will the network build the CHW workforce?

The randomized controlled trials that have tested the use of CHWs to provide more culturally attuned support often deploy CHWs to work in a specified healthcare setting (e.g.; lactation support in the hospital post-childbirth, primary care practice to represent social and behavioral needs of individuals with chronic illnesses, etc.). Given the nature of a research study, the CHWs are often deployed to the practices or hospitals for a time limited period to conduct the study versus employed by the practice or hospital. While for the purpose of the CCIP intervention networks will not only want CHWs for a limited time, contracting for CHW services to address equity gaps may be beneficial because different disparities will require CHWs of different backgrounds and different disease specific training. Given this and the desire to give the networks freedoms to establish a process to meet their needs, similar to complex patients, the standards will require that the networks define an approach to build the CHW workforce, but will not specify how (i.e.; employ vs. contract).

In addition to the CHWs, some studies utilize a CHW field supervisor to support the provision of care in the community and facilitate integration into the primary care setting (Perez-Escamilla R, 2014). The PTF believes this role is important and recommends it for Advanced Networks and FQHCs in Connecticut working with CHWs.

As with the complex patient intervention, the PTF felt that the introduction of CHWs into the primary care team would represent a paradigm shift in how care is delivered and will likely require training to reorient the primary care team to a new workflow, orient the primary team to new roles and responsibilities, and identify the goals of the CHW program. The PTF also agreed that the CHWs will require disease specific training for the equity gap that is being addressed as well as training that has a

greater emphasis on effective communication methods like motivational interviewing, health education and behavior change to support self-care management.

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).

Given this, the criteria for inclusion outlined above are met, but will also include the presence of social or behavioral risk factors and health literacy and/or language barriers. CHWs play a significant role in connecting patients to needed services and tailoring disease related and self-care management education to meet health literacy and language needs. Thus, the inclusion of these elements as criteria for connecting patients to a CHW will help identify patients who will receive the greatest benefit from the intervention.

3. What will the care plan and needs assessment look like? And how will they be administered?

The needs assessment for patients with equity gaps usually takes into account the historical and current challenges with self-care management, predominately taking into consideration socioeconomic risk factors, preferred language, and health literacy (Perez-Escamilla R, 2014). To ensure person-centeredness the PTTF also recommends taking into consideration personal preferences and values as well as family, social and cultural characteristics.

The care plan for individuals experiencing equity gaps is generally referred to as a self-care management plan because the goal of the plan is predominately intended to support the individual to gain the needed skills to manage their own care. As with any care plan it is informed by the needs assessment and will have clear goals and timeframes in which to accomplish those goals. The self-care management plan differs from the care coordination plan for complex patients in that it has a greater focus on providing culturally attuned health behavior change support with associated action steps that reflect an individual's readiness for change (Perez-Escamilla R, 2014). The PTTF agreed the care plan should have a focus on needed behavior change given the large role behavior often plays in the management of chronic conditions and also wanted to ensure person-centeredness through making it clear within the standards that the plan should be developed in collaboration with the patient and incorporate personal goals and preferences.

The needs assessment and self-care management plan will be completed by the CHW in collaboration with the patient. In research trials this is often done in the home (Anderson AK, 2005) (Perez-Escamilla R, 2014), but the PTTF felt it was important that the individual determine the location that is most convenient and in which they are comfortable.

4. How will the CHW successfully support the individual to meet the self-care management goals?

Research trials have specific CHW touch points with the individual in their home over a set period of time (e.g.; home visits monthly for 18 months) as well as weekly meetings with the individual's health care management team. During the CHWs interactions with the patient the self-care management plan

is often revisited and updated to reflect the individual’s progress (Anderson AK, 2005) (Perez-Escamilla R, 2014).

The PTF agreed that having a set schedule for in-person visits and interactions with the individual’s primary care team should be required, but the schedule with which these visits occurred should be determined by the Advanced Network or FQHC.

As with the complex patients, seamless communication about the individual’s health status and progress on the self-care management plan between the individual’s primary care team, the CHW, and any relevant social support services will be required for comprehensive management of the individual’s care. The PTF acknowledged and recommended the need for a technological solution to solve for seamless communication, but did not specify what that solution should be.

The Community Health Board collaborative standards the PTF is recommending for Advanced Networks and FQHCs will help to develop relationships with social support services to aid the CHWs in seamlessly connecting individuals to needed support.

Patients with Unidentified Behavioral Health Needs

A wealth of research exists that displays the positive impacts on cost and outcomes when behavioral health is better integrated into primary care or vice versa. Not only does better behavioral health management improve behavioral health outcomes, but it often also improves overall health status and reduces the overall cost of care (Brown D, 2014) (Community Health Network of Washington, 2013) (The Commonwealth Fund, 2014). The level of integration into primary care can vary and often follows a common framework:

COORDINATED Key Element: Communication		CO-LOCATED Key Element: Physical Proximity		INTEGRATED Key Element: Practice Change	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice
Behavioral health, primary care, and other health care providers work:					
In separate facilities, where they:	In separate facilities, where they:	In same facility not necessarily same offices, where they:	In same space within the same facility, where they:	In same space within the same facility (some shared space), where they:	In same space within the same facility, sharing all practice space, where they:
<ul style="list-style-type: none"> • Have separate systems • Communicate about cases only rarely and under compelling circumstances • Communicate, driven by provider need • May never meet in person • Have limited understanding of each other’s roles 	<ul style="list-style-type: none"> • Have separate systems • Communicate periodically about shared patients • Communicate, driven by specific patient issues • May meet as part of a larger community • Appreciate each other’s roles as resources 	<ul style="list-style-type: none"> • Have separate systems • Communicate regularly about share patients, by phone or e-mail • Collaborate, driven by need for each other’s services and more reliable referral • Meet occasionally to discuss cases due to close proximity • Feel part of a larger yet ill-defined team 	<ul style="list-style-type: none"> • Share some systems, like scheduling or medical records • Communicate in person as needed • Collaborate, driven by need for consultation and coordinated plans for difficult patients • Have regular face-to-face interactions about some patients • Have a basic understanding of roles and culture 	<ul style="list-style-type: none"> • Actively seek system solutions together or develop work-arounds • Communicate frequently in person • Collaborate, driven by desire to be a member of the care team • Have regular team meetings to discuss overall patient care and specific patient issues • Have an in-depth understanding of roles and culture 	<ul style="list-style-type: none"> • Have resolved most or all system issues • Communicate consistently at the system, team, and individual levels • Collaborate, driven by shared concept of team care • Have formal and informal meetings to support integrated model of care • Have roles and cultures that blur or blend

Reference: (Brown D, 2014)

The level of integration pursued is dependent on the behavioral health needs being addressed. As it might be expected, comprehensive management of patients with severe and persistent illness would more likely benefit from fully integrated care while patients with previously unidentified mental illness will likely benefit from a coordination model (Integrated Behavioral Health Project, 2013).

Based on the focus population the PTF - patients with previously unidentified behavioral health needs - the taskforce agreed that CCIP should create guidelines for a coordination model that outlines a consistent approach to:

1. Identifying when a patient has a behavioral health need
2. Determining if a referral is needed
3. Referring the patient to a behavioral health service when needed
4. Closing the communication loop between providers

To design this approach the PTF considered the following design questions:

1. What tools should be used to screen for behavioral health needs in the primary care setting?
2. How to determine if an individual should be treated in the primary care setting or referred to a behavioral health provider?
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?
4. How will the referral be tracked and the communication loop closed?

The PTF drew on existing research as well as the CT SIM Behavioral Health Design Group (BHDG), which is comprised of a number of behavioral health subject matter experts in the state, and received input from the PTF to answer these design questions.

1. What tools should be used to screen for behavioral health needs in the primary care setting?

Given the intent of this specific CCIP intervention, to broadly identify any previously unidentified behavioral health need, the BHDG discussed the need for the recommended screening tool(s) to be comprehensive enough to flag an array of needs. To ensure that key areas of behavioral health were covered by this tool, the PTF decided to require that the screening tool(s) assess the patient for depression, anxiety, substance abuse, and trauma at a minimum.

With the exception of depression, for which there is a nationally recognized screening tool (PHQ-9), the BHDG and PTF thought the networks should have the freedom to choose any standardized and validated tool for behavioral health needs outside of depression. The BHDG and PTF felt this freedom was beneficial for two reasons: 1) Outside of depression there are no tools that are nationally recognized as being the gold standard for screening and the data gained from networks implementing different screening tools may provide useful insight into which tools are better at flagging patients with a behavioral health need; and, 2) Different tools may be more prone to self-administration than others and the BHDG and PTF felt it was important that networks be able to decide whether or not tools would be self-administered or administered by an individual in the practice. The PTF also felt it was important to note that the screening tool is intended solely to flag behavioral health needs and not to

diagnose patients. Therefore, if the tool is administered by someone in the practice, it would not have to be a licensed behavioral health specialist. To ensure that screening is done consistently, the PTF recommended that at a minimum individuals are screened every two years and that networks develop processes for all routine primary care visits to identify if a re-screening is needed. The recommendation for screening with the PHQ-9 is also intended align with the Quality Council's recommendation that "Depression Remission at Twelve Months," which requires use of the PHQ-9 for the 12 month re-assessment.

2. How to determine if an individual should be treated in the primary care setting or referred to a behavioral health provider?

The primary considerations for whether or not an individual can be treated within the primary care setting include: (1) the specific behavioral health need and the severity of that need, and (2) the comfort level of the primary care provider in managing the condition and the medication regimen. In addition to these two factors, when it is possible that the individual be treated in either the primary care or a behavioral health care setting, the BHDG and PTF thought it was important that networks involve the individual and provide the needed education and support for the individual to make that decision.

Regardless of whether or not individuals are provided behavioral health care within the primary care setting or referred elsewhere, the PTF felt it was important that proper training is provided to the primary care providers on behavioral health promotion (e.g.; behavioral health resources in the community), detection, diagnosis, and when referrals are necessary.

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?

The BHDG and the PTF recommends that at least one Memorandum of Understanding (MOU) is executed with a behavioral health clinic and/or practice to promote accountability of both providers to follow the MOU specified protocols and processes. The BHDG and PTF is also recommending that processes and protocols are developed for referrals going to practices without an MOU as well. This will be necessary because likely one behavioral health clinic and/or practice will not be able to address all behavioral health needs and, the individual being referred should have the freedom to choose where to receive their behavioral health care and not be bound to the provider with which their primary care provider has an MOU.

4. How will the referral be tracked and the communication loop closed?

The BHDG and PTF recommend that the MOU and other protocols for remaining practices are developed that specify how relevant health care information will be exchanged between the primary care providers and the behavioral healthcare providers, an individual responsible for tracking the referral, and exploring technological solutions to automate confirmation that a referral has been completed. Among the relevant health care information that is exchanged, it must include the behavioral health care provider making the care plan available to the primary care provider to be incorporated into the primary care electronic medical record. The care plan should also specify what role the primary care provider can play in the care plan, if any.

Appendices

Appendix A: Community & Clinical Integration Program Standards

DRAFT

TARGET POPULATION: COMPLEX PATIENTS

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

Complex Patient Definition: Individuals who have either multiple complex medical conditions, multiple detrimental social determinants of health, or a combination of both that contribute to preventable service utilization and poorer overall healthcare management that ultimately negatively impacts the individual's overall health status.

Or

Individuals who need extra care due to complex medical issues that are often times compounded by social, economic, environmental, and behavioral factors. **[Alternative proposed for discussion]**

Program Description and Objective:

Description: The complex care management intervention will be person-centered and will target complex individuals to be connected to a comprehensive care team that is focused on identifying the individual's clinical and social needs, developing a plan to address those needs, and creating action steps so that the individual is both directing and involved in managing their care.

Person-Centered Definition: The individual self-determines and identifies their natural supports, which may include but is not limited to family, clergy, friends and neighbors and chooses whether to involve them in their medical care planning. The individual actively makes all decisions about their care plan and treatment. Person-centered care focuses on the individual's values, belief, preferences, and needs, and ensures that these factors guide all clinical decisions as well as non-clinical decisions that support independence, recovery and quality of life.

Objective: In the short-term, comprehensively address the identified barriers to care and healthy living and engage the individual directly in their own self-care. In the long-term, provide the individual with the appropriate resources and skills to improve their self-determination and feeling of empowerment to do longer-term self-care management. This will be accomplished by providing person-centered comprehensive care management, care coordination, education and self-management support services, skills training, and necessary connections to community and social support services.

High-Level Program Design:

1. Identify complex individuals
2. Establish a comprehensive care team workforce
3. Connect individuals to the comprehensive care team
4. Conduct person-centered assessment
5. Develop a care coordination care plan
6. Execute and monitor the care coordination care plan
7. Identify when individual is ready to transition to self-directed care maintenance
8. Monitor individuals to reconnect to comprehensive care team when needed
9. Evaluate the effectiveness of the intervention

1. Identify complex individuals

- The network identifies complex individuals who will benefit from comprehensive care team support by using basic analytics to develop a risk stratification⁵ methodology that takes into consideration utilization data (claims based), clinical, behavioral, and social determinant risks (EMR)⁶
- The network conducts a root cause analysis for the complex individual sub-population and identifies and implements at least one additional network capability to supplement the comprehensive care team intervention⁷
- The root cause analysis utilizes:
 - Relevant clinical data
 - Input from the complex individual sub-population⁸

2. The network establishes a comprehensive care team workforce

- The network develops a comprehensive care team that fulfills several functions⁹ including:
 - Case management
 - Clinically focused care coordination
 - Community focused care coordination to link individuals to needed social services and supports as well as culturally and linguistically aligned self-care management education.
 - The network includes a Community Health Worker¹⁰ on the comprehensive care team to fulfill the community focused function.
 - Oversight and management of the comprehensive care team
- The network provides timely access to or has a comprehensive care team member who is a licensed behavioral health specialist capable of a comprehensive behavioral health assessment¹¹
- The network adds comprehensive care team members outside of the above core functions (i.e.; dietitians, pharmacists, etc.) on an as needed basis depending on the needs of their specific patient population
- The network determines the best strategy for incorporating the members of the comprehensive care team into the primary care practices. Options include:
 - Employ members of the comprehensive care team within each primary care practice
 - Employ members of the comprehensive care team at one or more hub in support of multiple practices
 - Contract with members of the comprehensive care team¹²

⁵ See Appendix A for definition

⁶ See Appendix B for examples of the type of criteria used in other models

⁷ The CCIP elective capability standards can serve as guidance to the networks, but should not limit the scope of possibilities

⁸ Input can be solicited in a number of ways, including, but not limited to a community advisory board, a focus group, existing community meetings or community leadership

⁹ The networks will have the freedom to determine which care team members best fulfill these functions with the exception of the CHW, and can utilize licensed or unlicensed individuals to fulfill these roles

¹⁰ See Appendix A for definition

¹¹ See Appendix A for definition

¹² Likely the only member of the comprehensive care team for which contracting would be an option is the community health worker

- The network establishes the appropriate case load (individuals to team ratio) for the comprehensive care team¹³
- The network establishes training protocols on:
 - Identifying values, principles and goals of the comprehensive care team intervention
 - Redesigning the primary care workflow to integrate the comprehensive care team work processes
 - Orienting the primary care team to the roles and responsibilities of the comprehensive care team members¹⁴
 - Basic behavioral health training appropriate for all comprehensive community care team members
 - Delivering culturally and linguistically appropriate services standards consistent with Department of Health and Human Services, Office of Minority Health, CLAS standards
- The network develops and administers CHW training protocols or ensures that CHWs have otherwise received such training:
 - Person-centered assessment support
 - Outreach methods and strategies
 - Effective communication methods
 - Health education for behavior change
 - Methods for supporting, advocating and coordinating care for individuals
 - Public health concepts and approaches
 - Community capacity building (i.e.; improving ability for communities to care for themselves) (Boston, 2007)
 - Safety training geared toward maintaining safety in the home
- The network ensures training is provided:
 - To all primary care team members involved in the comprehensive care team intervention
 - On an annual basis to incorporate new concepts and guidelines and reinforce initial training

3. Connect individuals to the comprehensive care team

- The network implements a process to connect individuals to the complex care management support. Options for interacting with the individual include:
 - During the primary care visit
 - During an ED visit or inpatient hospital stay¹⁵
 - Pro-actively reaching out to the individual¹⁶

¹³ Optimal ratios should be determined by the network based on local needs

¹⁴ The PTF expressed that the network and its practices understanding of a Community Health Worker role is of particular importance as unlike other members of the care team their primary role is to support and coordinate care for the individual in the community, posing a significant departure from how care is more commonly delivered today

¹⁵ Networks could consider utilizing an ED/Inpatient technology that alerts the comprehensive care team upon admission and discharge of eligible individuals

4. Comprehensive care team conducts person-centered assessment¹⁷

- To understand the historical and current clinical, social and behavioral needs of the individual to inform the person-centered care coordination plan, the network conducts a person-centered needs assessment that includes¹⁸:
 - Preferred language
 - Family/social/cultural characteristics
 - Assessment of health literacy
 - Social determinant risks
 - Personal preferences, values, needs, and strengths
 - Assessment of behavioral health needs, inclusive of mental health, substance abuse, and trauma
 - The primary and secondary clinical diagnoses that are most challenging for the individual to manage
- Network defines process and protocols for the comprehensive care team to conduct the person-centered needs assessment that will include:
 - Defining where the person-centered needs assessment takes place¹⁹
 - Defining the timeframe within which the person-centered needs assessment is completed post-identification of individual need

5. Develop a person-centered care coordination plan²⁰

- The comprehensive care team and the individual and their natural supports²¹ collaborate to develop a person-centered care coordination plan²² that reflects the person-centered needs assessment and includes the following features:
 - Incorporates the individual's preferences and lifestyle goals
 - Establishes behavioral goals to address existing mental health, substance abuse, or trauma needs
 - Establishes social health goals to address largest social determinant risk factors as identified by the individual
- The network defines a process and protocol and protocol for the comprehensive care team to create a person-centered care coordination plan including location and timeframe for completion

6. Execute and monitor care coordination plan

- The network establishes protocols for regular comprehensive care team meetings that establish:
 - Who is required to attend²³

¹⁶ Experience in other states suggest that the individual who is pro-actively reaching out to individuals should be someone they identify with and who can build rapport with them (e.g.; a peer support or CHW) (Center for Healthcare Solutions, 2015)

¹⁷ See Appendix A for definition

¹⁸ See Appendix B for an example of a needs assessment

¹⁹ The PTF believes this should be determined by the individual

²⁰ See Appendix A for definition

²¹ Natural supports include but are not limited to, family, clergy, friends, and neighbors

²² See Appendix B for an examples of person-centered care coordination plans

- The frequency of the meetings
- The format of the meetings (i.e.; via conference call, in person, etc.)
- A standardized reporting form on the individual's progress and risks
- The network establishes protocols for monitoring individual progress on the person-centered care coordination plan that includes:
 - Establishing key touch points for monitoring and readjusting of the person-centered care coordination plan, as necessary
 - Establishing who from the comprehensive care team will be involved in the touch points
 - Developing a standardized progress note that documents key information obtained during the touch points
- The network modifies its process for exchanging health information across care settings to accommodate the role and functions of the comprehensive care team²⁴
- The network establishes a technology solution and/or protocols with local partners to alert the primary care provider and comprehensive care team when a patient is admitted or discharged from an ED, hospital, or other acute care facility to support better care transitions²⁵
- The network develops a process and protocols for connecting individuals to needed community services (i.e.; social support services) which include:
 - See: Community and Clinical Integration Program Shared Governance Standards

7. Identify when individual is ready to transition to self-directed care maintenance

- The network collaborates with the individual to assess their readiness to independently self-manage²⁶
- If desired by the individual, the network provides transitional support by connecting them to a Peer Support resource

8. Monitor individuals to reconnect to comprehensive community care team when needed

- The network establishes a mechanism to monitor transitioned individuals to notify the comprehensive care team when they are in crisis and need to be reconnected to the comprehensive care team²⁷

9. Evaluate the effectiveness of the intervention

- The network demonstrates that the comprehensive care team is improving health care outcomes and care experience for complex individuals by:

²³ Best practice suggests all members of the comprehensive care team and relevant primary care team members

²⁴ This will include establishing the necessary agreements with providers with whom information will be exchanged, identifying the type of information to be exchanged, timeframes for exchanging information, and how the organization will facilitate referrals

²⁵ SIM may support technology solution capable of alerting to admissions and discharge in the future. Protocols involving care transitions should focus on any updates/correction in the care plan as a result of the health event, in particular any updates in living conditions or personal preferences of the patient and caregivers, to ensure ongoing support in pursuit of patient goals

²⁶ See Appendix B for sample tool

²⁷ The network could consider utilizing a ED/Inpatient admission/discharge alert technology for monitoring

- Tracking aggregate clinical outcome, individual care experience, and utilization measures that are relevant to the target population's needs (i.e.; complex individuals)²⁸
- Achieving improved performance on identified measures
- Identify opportunities for quality process improvement. This will require:
 - Defining process and outcome measures specific to the comprehensive care team intervention
 - Establishing a method to share performance²⁹ data regularly with comprehensive care team members and other relevant care providers to collectively identify areas of improvement

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²⁸ Clinical measure and experiences measures for complex individuals should be determined based on the most prevalent clinical areas of need for the network's complex individuals (e.g.; behavioral health) and lower performing experience measures; utilization measures will likely include inpatient admissions for ambulatory sensitive conditions, readmissions, and ED utilization

²⁹ Performance is commonly shared through a dashboard or scorecard. Networks should also consider establishing learning collaboratives that bring together the different practices in their network to share best practices

HEALTH EQUITY: CONTINUOUS QUALITY IMPROVEMENT STANDARDS

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

Program Description and Objective:

Description: Equity gap quality improvement will provide a standardized processes for networks to use data to identify and address healthcare disparities.

Objective: Provide Advanced Networks and Federally Qualified Health Centers (FQHCs) with a set of data/analytic standards that will enable them to identify disparities in care on a routine basis, prioritize the opportunities for reducing the identified disparities, implement interventions, and evaluate the effectiveness of the intervention.

High-Level Process:

1. Analyze clinical performance and/or individual experience stratified by sub-populations
2. Identify and prioritize opportunities to reduce health care disparities
3. Implement at least one intervention to address the disparity
4. Evaluate the effectiveness of the intervention

1. Analyze clinical performance and/or individual experience stratified by sub-populations

- The network analyzes select clinical performance and individual experience measures stratified by race/ethnicity and language
 - This will require that the network at a minimum capture Office of Management and Budget (OMB) race/ethnicity categories and preferred language in their EMR
- The network identifies valid clinical and care experience performance measures to compare clinical performance between sub-populations
 - Initially networks will use performance metrics aligned with the CT SIM quality scorecard³⁰
 - Additional metrics are quantifiable and address outcomes rather than process whenever possible.
 - Metrics should meet generally applicable principles of reliability, validity, sampling and statistical methods.
- The network establishes method of comparison between sub-populations
 - Clinical outcome and individual experience measure can be compared internally amongst the network population or compared to a benchmark³¹
 - For the CCIP pilot intervention the proposed sub-populations are pre-defined as White, Black, and Latino to ensure that there are large enough sample sizes to make valid statistical inferences.

³⁰ The CT SIM Quality Scorecard is still in process, but will likely include diabetes, hypertension and asthma clinical performance measures

³¹ Networks not performing well against a national/regional benchmark may want to consider starting by comparing internally while networks with little disparity between in-network sub-populations may benefit from utilizing a benchmark.

- The stratification by race/ethnicity should be informed by the demographics of the population served by the network

2. Identify and prioritize opportunities to reduce health care disparities

- The network documents and makes available to the technical assistance vendor the results of the opportunities identified through data analysis
- The network develops a process to prioritize opportunities. Prioritization considers:
 - Significance to individuals in the sub-population experiencing a disparity in care, which is evaluated through engaging members of the sub-population to prioritize opportunities

3. Implement at least one intervention to address the disparity

- The network conducts a root cause analysis for the disparity identified for intervention and develop an intervention informed by this analysis
- The root cause analysis utilizes:
 - Relevant clinical data
 - Input from the target sub-population for whom a disparity was identified
 - Input from the target-sub population solicited through various venues
- The network designs an intervention and describes how the intervention will meet the needs/barriers identified in the root cause analysis
- The network involves members of the sub-population who are experiencing the identified disparity to design the interventions
- The network includes a Community Health Worker as a component of their intervention³²
 - Standards for incorporating a Community Health Worker into the network to be available to and integrated into the primary care practice to support individuals experiencing the identified disparity who would benefit from the additional support of a CHW [see: Health Care Disparity Focused Community Health Worker Standards]
- The network implements an intervention in at least five practices

4. Evaluate the effectiveness of the intervention

- The network demonstrates that the intervention is reducing the health care disparity identified by:
 - Tracking aggregate clinical outcome and individual experience measures aligned with the measures used to establish that a disparity existed
 - Achieving improved performance on measures for which a disparity was identified
- Identify opportunities for quality and process improvement. This will require:
 - Defining process and outcome metrics for the interventions pursued
 - Establishes a method to share performance³³ regularly with relevant care team participants to collectively identify areas for improvement

³² Research has shown CHWs to effectively address healthcare disparities arising from cultural and language barriers to self-care management and education. Accordingly, it is expected that the CHW will only be one component of the intervention and is being recommended as a required intervention by CCIP.

³³ Performance is commonly shared through a dashboard or scorecard. Networks should also consider establishing learning collaboratives that bring together the different practices in their network to share best practices

TARGET POPULATION: INDIVIDUALS EXPERIENCING EQUITY GAPS
INTERVENTION STANDARDS

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

Program Description and Objective:

Description: The equity gap intervention will focus on:

- 1) Reducing health equity gaps through standardizing certain elements of the care processes to be more culturally and linguistically appropriate; and,
- 2) Developing processes in the primary care practice to identify individuals experiencing gaps in their health outcomes who would benefit from more culturally attuned care interventions and connect them to those interventions

The standardization of certain elements of care will include the re-engineering of care processes to optimize performance and minimize sub-population specific barriers in the care pathway. The culturally specific interventions will include:

- Use of a community health worker who has culturally and linguistically sensitive training to educate individuals about their condition and empower them to better manage their own care,
- Producing translated and culturally appropriate educational materials

For the first wave of Advanced Network and Federally Qualified Health Center participation in CCIP, the intervention should focus on sub-populations defined by large race and ethnic populations, specifically White, Black, and Latino. The intervention should be further limited to diabetes, hypertension and asthma, as these conditions are likely to be included in the SIM Core Quality Measure set. The Advanced Network or FQHC may propose an alternative area of focus based Advanced Network or FQHC individual demographics and performance data.

The primary purpose of the intervention is to develop these skills with a target sub-population and condition so that these same skills can then be applied to other sub-populations and conditions. It is expected that the Advanced Networks and FQHCs will examine their performance with smaller sub-populations such as Southeast Asian or Cambodian populations and adopt similar methods to close health equity gaps.

Objective: Narrow the specific gap in care identified and maintain improvement. The community health worker will support the initial improvement and long-term maintenance of health outcomes for the sub-population identified through the provision of culturally sensitive medical education about their condition, behavior change education to promote a healthy lifestyle, and identifying and connecting the individual to needed support services.

High-Level Health Equity Gap Intervention Design:

1. Create a more culturally and linguistically sensitive environment
2. Establish a CHW workforce
3. Identify individuals who will benefit from the culturally attuned supportive services of a CHW
4. Conduct a person-centered needs assessment
5. Create a person-centered self-care management plan

6. Execute and monitor the person-centered self-care management plan
7. Identify process to determine when an individual is ready to transition to self-directed maintenance

Standards

1. Create a more culturally and linguistically sensitive environment

- The identified practices provide culturally and linguistically appropriate services informed by the root-cause analysis conducted around the identified health care disparity.
 - Practices provide interpretation/bilingual services as necessary
 - Practices provide printed materials (education and other materials) that meet the language needs of the individual and are comprehensible to all individuals

2. The network establishes a CHW workforce

- The network determines the best strategy for incorporating community health workers and the community health worker field supervisor(s) into the primary care practices. Options include:
 - Employ the CHWs/CHW field supervisor within the practice
 - Employ the CHWs/CHW field supervisor at one or more hubs in support of multiple practices
 - Contract with community organizations for CHW/CHW field supervisor services
- The network documents process for how CHWs will be made available to individuals across the network
- The network establishes the appropriate case load (individuals to team ratio) for the CHW³⁴
- The network establishes training protocols on:
 - Identifying values, principles, and goals of the CHW intervention
 - Redesigning the primary care workflow to integrate the CHWs work process
 - Orienting the primary care team to the roles and responsibilities of the community health worker
- Network ensures training is provided:
 - To all primary care team members involved in the CHW intervention
 - On an annual basis to incorporate new concepts and guidelines and reinforce initial training
- The network develops and administers CHW training protocols or ensures that CHWs have otherwise received such training:³⁵
 - Person-centered assessment and support
 - Disease specific training informed by endorsed training protocols³⁶
 - Outreach methods and strategies
 - Effective communication methods
 - Health education for behavior change
 - Methods for supporting, advocating, and coordinating care for individuals

³⁴ Optimal ratios should be determined by the network based on local needs

³⁵ CT is expanding access to CHW education and training so it should be easier to recruit CHWs with basic competencies; training in role/function specific competencies will need to be undertaken by the network.

³⁶ The disparity gap being addressed will determine the type of disease-specific training

- Public health concepts and approaches
- Community capacity building (i.e.; improving ability for communities to care for themselves)
- Safety training protocols geared at maintaining safety in the home
- Basic level of behavioral health training, so the community health worker can recognize behavioral health needs

3. Identify individuals who will benefit from CHW support

- Network identifies individuals who will benefit CHW support by developing criteria that assesses:
 - The individual is part of the sub-population targeted for intervention
 - Lack of health status improvement for the targeted clinical outcome
 - Presence of social determinant or other risk factors associated with poor outcomes
 - Health literacy and/or language barriers

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:
 - Preferred language
 - Family/social/cultural characteristics
 - Behaviors affecting health
 - Assessment of health literacy
 - Social determinant risks
 - Personal preferences and values
- Network defines the process and protocols for the CHW to conduct the person-centered needs assessment³⁷

5. Create a self-care management plan

- The CHW and the individual and their natural supports³⁸ collaborate to develop a self-care management plan that includes the following features:
 - Incorporates the individual's preferences and lifestyle goals
 - Establishes health behavior goals that will improve self-care management and are reflective of the individual's stage of change³⁹
 - Establishes social health goals that will improve self-care management and are reflective of needs/barriers identified in the person-centered needs assessment
 - Identifies actions steps for each goal and establishes a due date⁴⁰

³⁷ Should identify where the person-centered needs assessment should be conducted which should be determined by the patient and the timeframe within which it should be completed post CHW intervention enrollment

³⁸ Natural supports include but are not limited to, family, clergy, friends, and neighbors

³⁹ Stage of change refers to the Prochaska's stages of change model that categorizes how ready an individual is to change their behavior. Stages include: pre-contemplation (not ready), contemplation (getting ready), preparation (ready), action, and maintenance

⁴⁰ See Appendix B for examples from other programs

- The network defines a process and protocols for the CHW to create the person-centered self-management plan including location and timeframe for completion⁴¹

6. Execute and monitor the person-centered self-care management plan

- The network establishes protocols for regular CHW led care team meetings that establish:
 - Who is required to attend⁴²
 - The frequency of meetings
 - The format for the meetings (i.e.; via conference call, in person, etc.)
 - A standardized reporting structure on the individual's progress and risks⁴³
- The network establishes protocols for monitoring individual progress on the person-centered self-care management plan the includes:
 - Establishing key touch points with the individual for monitoring and readjusting of the person-centered self-care management plan, as necessary
 - Establishing who, in addition to the CHW, will be involved in the touch points
 - Developing a standardized progress not that documents key information obtained during the touch points
- The network modifies its process for exchanging health information across care settings to accommodate the role and functions of the CHW support⁴⁴
- The network develops a process and protocols for connecting individuals to needed community services (i.e. social support services) which include:
 - See: Community and Clinical Integration Program Shared Governance Standards

7. Identify process to determine when an individual is ready to transition to self-directed maintenance

- The network develops criteria to evaluate when the individual has acquired the necessary education and self-care management skills to transition to self-directed maintenance that includes:
 - Collaborating with the individual to assess their readiness to independently self-manage their care
 - Assessing improvement on the relevant clinical outcomes

⁴¹ The network should determine where the self-care management plan should be completed which should be determined by the patient and a timeframe for completion post needs assessment should be established

⁴² Best practice suggests the following attendees: CHW, CHW field supervisor, key members of the primary care team, including the primary care provider

⁴³ The intention of this report is to provide the team with an update, but also to alert the team to any key areas of concern that the broader team might be able to address

⁴⁴ The network should have agreements with necessary care providers about exchanging information; establish the type of information to be shared (consider needs assessment self-care management plan and patient progress notes ;timeframes for exchanging information; and, how the organization facilitates referrals

BEHAVIORAL HEALTH INTEGRATION STANDARDS

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

Program Description and Objective:

Description: The behavioral health integration standards will incorporate standardized, best-practice processes to identify unidentified behavioral health needs in the primary care setting. This program seeks to bolster the ability of providers to perform these functions as well as optimize existing resources.

Objective: To improve the ability of healthcare providers to identify and treat behavioral health needs and to improve the overall state of behavioral health in Connecticut.

High-Level Process:

1. Identify individuals with behavioral health needs
2. Address behavioral health needs
3. Behavioral health communication with primary care source of referral
4. Track behavioral health outcomes/improvement for identified individuals

1. Identify individuals with behavioral health needs⁴⁵

- 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:
 - Depression
 - Anxiety
 - Substance abuse
 - Trauma
- The network develops a screening tool that can be self-administered or administered by an individual who does not have a mental health degree⁴⁶ that includes:
 - The PHQ-9 to screen for depression
 - Standardized and validated screening tools for behavioral health needs outside of depression
- The network ensures there are support services to administer the tool for individuals with barriers to filling out the screening tool on their own⁴⁷

⁴⁵ The screening is not intended to identify individuals with severe and persistent mental illness

⁴⁶ The tool does not have to screen for a diagnosis but screen for areas of concern for follow-up by a licensed behavioral health specialist, and the individual who administers the tool should be trained to flag when follow-up screening of additional needs is required by a licensed clinician. Patients aged 12 and older, when possible, should complete the screening tool without the support of their parents.

⁴⁷ The networks should encourage patients aged 12 or older, when possible, to complete the screening tool without the support of their parents.

- The network utilizes a trained behavioral health specialist on site or through referral (at least with masters level training) who is expected to do a more targeted follow-up assessment⁴⁸ with the individual when necessary
- The network conducts the behavioral health screening no less often than every two years
- The network develops a process for identifying a re-screening at each routine visit⁴⁹
- The screening tool results are captured in the EMR and made accessible to all relevant care team members

2. Address behavioral health need

- The network conducts an assessment of needed behavioral health resources among the advanced network/FQHC network population and establishes the necessary relationships to meet those needs
- The network develops a standardized set of criteria to determine whether or not the behavioral health need can be addressed in the primary care setting by a primary care provider that considers⁵⁰:
 - The diagnosis/behavioral health need
 - Severity of the need
 - Comfort level of the primary care team to manage the individual's needs
 - Complexity of the required medication management
 - Age of the individual
 - Individual preference
 - If the provider doing medication management for the individual has psychiatric medication management training
- The practice establishes a mechanism for identifying available behavioral health resources and educates the individual on what these resources are regardless of whether or not a referral is needed.⁵¹
- Primary care providers providing behavioral health care will have behavioral health training that covers:
 - Behavioral health promotion, detection, diagnosis, and referral for treatment⁵².

⁴⁸ The assessment should reflect the needs identified by the screening tool.

⁴⁹ This re-screening could include questions asked about changes by doctor or nurse as part of routine visit.

⁵⁰ If the individual can be treated in the primary care setting, it is expected that the individual be engaged to determine where they would prefer to receive care including primary care provider in the primary care setting, a behavioral health specialist in a behavioral health setting, or behavioral health specialist in a primary care setting if possible. If the individual's needs cannot be addressed in the primary care setting, it is expected the individual be engaged to inform and educate them on the diagnosis/behavioral health need and why a referral/care from a behavioral health specialist is recommended. The individual who engages the individual should be the behavioral health trained care provider with whom the individual is most comfortable.

⁵¹ These resources may include but are not limited to: community resources (e.g.; support groups, wellness centers, etc.); alternative therapies (e.g.; acupuncture); and health promotion services (e.g.; women's consortium).

⁵² The technical assistance vendor will assist the networks to find appropriate trainings that focus on health promotion, detection, diagnosis and referral for treatment. Trainings identified by the vendor should be made available to all networks via the internet.

- If behavioral health services are not in network, the network executes an MOU with at least one behavioral health clinic and/or practice and develops processes and protocols for all other practices that include⁵³
 - Guidelines on how information will be exchanged and within what timeframe
 - Designating an individual to be responsible for tracking and confirming referrals⁵⁴
 - Developing technology, if possible, to alert the primary care practice when a referral is completed
 - Defining a timeframe within which a referral should be completed⁵⁵
 - Appropriate coding and billing⁵⁶

3. Behavioral health communication with primary care source of referral

- The network develops process, protocol, and technology solutions identified for behavioral health provider to make the assessment and care plan available to the primary care team with appropriate consent
 - The behavioral health care plan outlines treatment goals, including when follow up is required and who is responsible for follow up
 - The behavioral health provider is available for consultation as needed by the primary care physician (process for this should be outlined by MOU) if individual is transferred back to the primary care setting

4. Track behavioral health outcomes/improvement for identified individuals

- The network utilizes individual tracking tool to assess and document individual progress at one year and other intervals as determined by the provider
- The network develops processes and protocols for updating this tracking tool that includes⁵⁷:
 - Who is responsible for updating
 - Defining intervals at which assessments are made
 - Adjusting treatment when not effective

⁵³ This is recommended to ensure that an individual who chooses to seek care from a provider outside of the network or with whom there is no MOU is still assisted and supported in the referral process and does not feel pressured to receive care from a limited set of providers. Additionally, behavioral health needs vary and it may not be realistic to have providers in the network or MOUs with the extent of providers that cover the breadth of behavioral health needs that may arise (e.g.; addiction treatment, depression, anxiety, etc.). Processes and protocols should identify how information will be exchanged with provider for whom there is not an MOU (e.g.; release of information)

⁵⁴ Consider a designated behavioral health referral coordinator

⁵⁵ Completed means the consultation occurred and information on the consultation was shared with the primary care practice

⁵⁶ Pending policy developments around same day billing for behavioral health services may alleviate the need for this to be required of the MOU

⁵⁷ Consider technological solutions for tracking outcomes such as a disease registry

COMMUNITY CONSENSUS LINKAGES PROCESS AND GUIDELINES

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

Program Context, Description, and Objective:

Context: One of the core drivers of success in Connecticut's SIM Community and Clinical Integration Program initiative involves the integration of healthcare delivery with community resources capable of addressing the socio-economic determinants of poor health outcomes. Currently, due to the lack of integration and coordination across care settings, too few patients are connected to those resources, especially those with complex conditions and experiencing equity gaps. Because many of these important community service providers are resource-, capacity-, and geographically-constrained, there is concern that having multiple sets of disparate networks seeking partnerships from across Connecticut for their own patients with their proprietary processes and protocols will place unmanageable burdens on these community resources, which are by definition intended to serve the entire community. In this case, rather than require providers to build their own social service capabilities, which would be both outside of the scope of their core competencies and an inefficient use of resources, many SIM states have successfully initiated this integration process by establishing systems of shared governance for community resources (Samuelson, 2015). For the purposes of integrating social support services into clinical care for Connecticut's CCIP initiative, the PTF has recommended a similar approach of convening community stakeholders to establish local Community Health Board Collaboratives. This convening responsibility will be included in the RFP for the transformation vendor responsible for providing technical assistance to participants in the CCIP program. The SIM PMO will include the responsibilities as well as the experience and skills required for this role, which will include experience dealing with healthcare, consumer, and community organizations and experience facilitating diverse groups of stakeholders to develop consensus-based processes and protocols. While this convening responsibility will initially remain with the transformation vendor due to the time and resource requirements to launch the effort, the responsibilities to maintain the Community Health Board Collaboratives will be transitioned to community leaders according to an agreed upon transfer plan.

Description: Community Consensus & Linkages guidelines will establish a process for communities to streamline the linkage to and provision of important socio-economic services related to the health needs of patients. This system of shared decision-making helps further the integration of community services with healthcare services and may prepare communities for the next generation of shared accountability under population health related SIM initiatives. The community consensus guidelines will impact patients with complex conditions and health equity gaps, who are disproportionately in need of better coordination with social service providers.

Objective: To facilitate the connection of patients with socio-economic conditions contributing to poor health outcomes with community resources capable of addressing those needs in a coordinated way with the primary care provider and/or care team and in a way that is most efficient for the primary care team and community services providers.

High-Level Shared Community Health Board Collaborative Development Process:

1. Transformation vendor responsibilities
2. Identify and convene stakeholders impacted by the Health Board Collaborative model in defined area(s)
3. Develop standardized protocols and processes for network linkages to shared services
4. Implement long-term assessment and improvement process

Detailed Community Health Board Collaborative Design Standards for Technical Assistance Vendor:

Standards

1. Transformation vendor expectations -

- The transformation vendor develops policies to ensure the Health Board Collaborative process is unbiased, inclusive of relevant stakeholders, and person-centered in its vision and goals. Outline includes the following:
 - Conflict of interest policies
 - Code of ethics for participation
 - Plans and timelines for regular meetings including for the transfer of convening responsibilities to a local board
 - Goals and objectives

2. Identify and convene stakeholders impacted by Health Board Collaborative model in defined service area(s) -

- The vendor convenes social service, healthcare, and community stakeholders who are representative of the service area for which the Health Board Collaborative oversees. Representative stakeholders at a minimum include:
 - Social services providers reflective of the socio-economic and health needs of the patient populations being served, informed by the root cause analyses conducted for health care disparities and complex patients⁵⁸
 - Local government agencies with health focused missions (e.g.; public health, municipal leadership)
 - Healthcare providers from across the continuum of care (i.e.; hospitals, LTSS, primary care practices, VNA/home health, FQHCs, specialists, behavioral health and dental providers, pharmacists, etc.)
 - United Way (2-1-1)⁵⁹
 - Consumers representative of the service area familiar with the target social, environmental and healthcare needs
- The vendor establishes a schedule for meetings that are open to the public

3. Develop standardized protocols and processes for network linkages to shared services

- The Health Board Collaborative defines shared services and community linkages according to the local needs of the networks⁶⁰

⁵⁸ Relevant socio-economic domains include, but are not limited to housing, nutrition, employment/vocational assistance, education, transportation, and legal assistance

⁵⁹ United Way representation will be required due to the central role they play statewide to catalogue reliable social service resources and access to data on the community's needs through their 2-1-1 program

- The Health Board Collaborative, with facilitation by the vendor, identifies operational areas appropriate for standardization working with networks to identify local needs⁶¹
- The Health Board Collaborative develops protocols and processes that reflect the needs, resources, and capabilities of the local community in delivering integrated, person-centered care to individuals as follows:⁶²
 - Solicits input from patients and consumers to ensure the needs of the community are reflected⁶³
 - Considers the capacity and capabilities of the healthcare and social service providers in the community⁶⁴
- The Health Board Collaborative develops an implementation plan and process for proposed standardized processes and protocols across the networks and community partners

4. Implement long-term assessment and improvement process -

- The Health Board Collaborative transitions convening responsibilities to a board of local stakeholders pursuant to agreed-upon plan
- The Health Board Collaborative holds regular meetings and forums to collect concerns and feedback on potential improvements
- The Health Board Collaborative incorporates a data collection and analytics function to determine the impact of these new protocols
 - Analytics will compare health outcomes and utilization compared to a relevant baseline coordinating with the SIM PMO
- The Health Board Collaborative will update and modify these protocols over time given the results of the analytics and the feedback from collaborative participants

⁶⁰ Shared services and community linkages include services where multiple networks call on a limited resource in the community with separate processes and protocols. This may include hospitals serving multiple networks.

⁶¹ The Community Health Board Collaborative can assist networks with their needs assessments as needed and help to aggregate data and analysis.

⁶² Protocols to be standardized will be dependent on service area and community but may include: public awareness, education, and communication of the availability of community services; clinical processes for connecting individuals to community services (e.g. standardized transition checklist); and management of referrals and systems for verifying follow-up appointments.

⁶³ This includes ensuring that communications around processes for accessing needed services are culturally and linguistically appropriate

⁶⁴ Because technology systems, methods of communication, and capacity to handle increased administrative tasks will vary across Connecticut, the community collaborative must strive to develop processes and protocols that reflect the reality of all participating community and healthcare providers in a way that does not place unmanageable burdens on organizations.

ORAL HEALTH INTEGRATION STANDARDS

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

Program Description and Objective:

Description: The oral health integration standards provide a process for primary care practices to routinely screen individuals for oral health needs and when necessary connect individuals to an oral health provider.

Objective: Improve dental health for all populations as well as overall health. It is well acknowledged that there is an oral/systemic link (Qualis Health, 2015). An individual's oral health can impact their overall health and vice versa, in particular when individuals have certain chronic conditions like diabetes. These standards will put processes in place that promote treating the individual in a manner that acknowledges the oral-systemic links.

High Level Intervention Design:

1. Screen individuals for oral health risk factors and symptoms of oral disease
2. Determine best course of treatment for individual
3. Provide necessary treatment – within primary care setting or referral to oral health provider
4. Track oral health outcomes/improvement for decision support and population health management

Standards:

1. Screen individuals for oral health risk factors and symptoms of oral disease

- The network develops a risk assessment⁶⁵ that will be reviewed by the primary care provider to screen all individuals for oral health needs using a tool that includes questions about:
 - The last time the individual saw a dentist
 - Name of dentist and location/dental home if applicable⁶⁶
 - Oral dryness, pain and bleeding in the mouth
 - Oral hygiene and dietary habits
- The network determines a process and protocol to administer the risk assessment that identifies:
 - The format of the assessment (i.e.; written or verbal)
 - Who administers the assessment (can be anyone in the practice)
- The network identifies a process to flag individuals for follow-up for further evaluation and basic intervention that includes the primary care based preventive measures detailed in section two
- The network develops an oral examination⁶⁷ procedure of the entire oral cavity that includes:
 - Assessment for signs of active dental carries (white spots or untreated cavities)
 - Poor oral hygiene (presence of plaque, or gingival inflammation)

⁶⁵ See Appendix B for a link to sample risk assessments

⁶⁶ A "dental home" means an ongoing relationship between a dentist and an individual, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated and person or family-centered way (reference: CTDHP Dental Home Definition)

⁶⁷ See Appendix B for sample Oral Exam

- Dry mouth (no pooling saliva and/or atrophic gingival tissues)
- Pre-cancer and cancerous lesions
- The network determines who is responsible for conducting oral exam⁶⁸ and ensures appropriate oral health training and education⁶⁹ is received by the care team members conducting the exam.

2. Determine best course of treatment for individual

- The network designates care team member(s) to review the risk assessment and the oral exam with the individual⁷⁰
- The network develops a set of standardized criteria to determine the course of treatment that includes:
 - Consideration for the answers on the risk assessment, findings from the oral exam, and individual preferences
 - Identification of which prevention activities can be provided in the primary care setting⁷¹

3. Provide necessary treatment – within primary care setting or referral to oral health provider

- The network will determine who in the primary care setting is responsible for delivering preventive care⁷²
- The networks provides prevention education and materials in the primary care setting, ideally by a trained health educator or care manager⁷³, that includes:
 - Providing free products that support dental hygiene (e.g.; toothbrush, floss, etc.)⁷⁴
 - Using the built in EMR tools that provide standardized education to the individual based on diagnosis
 - Training existing team members to provide the needed services (e.g.; LPNs)
 - Crafting educational messages on prevention that can be provided by all members of the care team in the absence of a health educator or care manager

⁶⁸ The oral exam can be conducted by anyone on the care team who has received the proper oral health training and education, but Medicaid only reimburses for the exam if it is conducted by a PCP, APRN, or PA for children under 3. Currently in discussions with DSS to reimburse for a broader age range

⁶⁹ See Appendix B for possible training and education tools

⁷⁰ Any member of the care team can review findings of the assessment and the exam with the individual, but as a general rule the severity of the condition should dictate the level of the person who interacts with the individual (e.g.; if there is a concern about oral cancer findings should be shared by a primary care provider, if a referral is needed it can be shared by another member of the team)

⁷¹ The following prevention activities are usually provided in the primary care setting: changes to medication to protect the saliva, teeth, and gums; Fluoride varnish application whenever applicable or subscription for supplemental fluoride for children not drinking fluoridated water (information on fluoridated water testing: <http://oralhealth.uchc.edu/fluoridation.html>); dietary counseling to protect teeth and gums, and to promote glycemic control for individuals with diabetes; oral hygiene education and instruction; therapy for tobacco, alcohol and drug addiction

⁷² Preventive care provided in the primary care setting can be provided by any member of the care team with the exception of changing medications which needs to be done by the primary care provider

⁷³ If a health educator or care manager is not available other members of the care team can be trained to provide education

⁷⁴ The Connecticut Dental Partnership can be a resource for this – issues free products and referral information <https://www.ctdhp.com/default.asp>

- Providing written materials such as a handout in the waiting room or an after visit summary as supplemental education
- The network develops a process and protocols to make, manage, and close out referrals that include:
 - Identifying a preferred dental network for referrals for individuals who do not have a usual source of dental care
 - Coordinating to share the necessary health information with the individual's dental network which includes:
 - Individual's problem list
 - Current medication and allergies
 - Reason for the referral
 - Confirmation that the individual is healthy enough to undergo routine dental procedures
 - Confirming the individual made an appointment with the dentist and the date of the appointment
 - Receiving a summary of the dentist's findings and treatment plan upon completion of the dental visit for inclusion in the individual's health record
 - Developing technology solutions for sharing necessary information between primary care providers and dental providers⁷⁵
 - Designating an individual to be responsible for tracking and coordinating referrals, confirming that the dental appointment was made, occurred, and the agreed upon material was shared between providers
 - Providing additional support services where/when possible (i.e.; transportation, interpretation, etc.)

4. Track oral health outcomes/improvement for decision support and population health management

- The networks electronically captures the following items⁷⁶:
 - Risk assessment results
 - Oral exam results
 - Interventions received: referral order, preventions in clinic
 - Documentation of completed referral
- The network monitors and reports on integration process that supports quality improvement and holding the primary care and dental partners accountable to the established agreements

⁷⁵ Networks should consider technologies such as direct messaging or secure messaging

⁷⁶ Networks should consider capturing data in a structured manner (i.e.; delimited fields vs free text) so data can easily be tracked for reporting purposes

eCONSULTS STANDARDS

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

Program Description and Objective:

Description: eConsults is a telehealth system in which Primary Care Providers (PCPs) consult with a specialist reviewer electronically via “eConsult” 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. eConsult 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 eConsult
 1. Primary care provider places eConsult 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 eConsult

- The network defines for which specialty they will do eConsults⁷⁷
- The network involves the individual in the decision to utilize an eConsult and will send eConsults for all individuals who require the service of the designated specialty and who assent to eConsult, with the exception of individuals with urgent conditions and those who have a pre-existing relationship with a specialist

2. Primary care provider places eConsult to specialist provider

- The network designates with which specialty practice or specialty providers it will coordinate eConsults⁷⁸.

⁷⁷ Policy reports done in Connecticut by UCONN and Medicaid explored the use of eConsults 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)

⁷⁸ If the network does not have specialists in their network, they may want to consider establishing an eConsult 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:
 - Standard form text options to ensure important details are shared
 - Free text options to the opportunity for the primary care provider to share additional details of importance (Kim-Hwang JE, 2010)
 - 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 eConsults to the specialty practice and/or providers designated to do eConsults⁷⁹
- The network develops a process and protocol to send eConsults to the designated specialty practice and/or providers that includes:
 - Identifying an individual in the primary care practice responsible for sending the eConsult to the specialty practice and/or providers
 - Setting a timeframe within which the eConsult should be sent post-primary care visit
 - Establishing a payment method for the eConsult service⁸⁰
- The specialty practice and/or provider develops a process and protocol to receive and review the eConsult that includes:
 - Identifying a coordinator whose responsibility it is to receive and prepare the consult for review
 - Setting a timeframe within which the eConsult 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:
 - The individual does not need a referral
 - The individual may need a referral but additional information is needed from the primary care provider (i.e.; additional history, additional tests run, etc.)
 - 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 eConsult outcomes that include:
 - Setting a timeframe within which the specialist notifies the primary care practice of eConsult result regardless of the outcome
 - 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

⁷⁹ 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

⁸⁰ Currently Medicaid covers eConsults

- Identifying how the primary care provider will notify the individual that follow-up is needed and process for scheduling additional testing, if necessary
- 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

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COMPREHENSIVE MEDICATION THERAPY 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 Medication Therapy Management (MTM) intervention will be an elective CCIP capability for patients with complex therapeutic needs who would benefit from a comprehensive personalized medication management plan. MTM is a system-level, person-centered process of care provided by pharmacists to optimize the complete drug therapy regimen for a patient's given medical and socio-economic condition. The MTM evidence-based model, according to 11 national pharmacy organizations, is "dependent upon pharmacists working collaboratively with physicians and other healthcare professionals to optimize medication use in accordance with evidence-based guidelines."⁸¹ In the context of CCIP, this intervention will be relevant for all patients who are experiencing adverse effects due to 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 assess, resolve, and prevent medication mismanagement by engaging patients and their caregivers in better therapeutic management techniques in order to reduce the overall burden of pharmacy management and the risk of adverse outcomes.

High-Level Program Design:

1. Identify patients requiring comprehensive medication therapy management
2. Pharmacist consult with patient and caregiver in coordination with PCP/care team
3. Develop a person-centered medication plan
4. Implement person-centered medication action plan

Detailed Program Design:

Standards

1. Identification of patients requiring comprehensive MTM

- The network defines criteria to identify patients with complex and intensive needs related to their pharmacy regimen that would be conducive to pharmacist intervention⁸²;
- The network develops a process for the responsible professional and/or care team to assess patient medication therapy management needs⁸³

⁸¹American Pharmacists Association, and National Association of Chain Drug Stores Foundation. *Medication Therapy Management in Pharmacy Practice: Core Elements of a MTM Service Model Version 2.0*. March 2008.

⁸² 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 pharmacy mismanagement (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

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

- The Advanced Network or FQHC picks a pharmacist integration model that aligns with their current network needs/current state.⁸⁴
 - Regardless of the model, the pharmacist receives training to interact directly with the patient and/or caregiver in a person-centered way and to understand their goals of care in order to provide MTM as part of a clinical team. Training includes⁸⁵:
 1. Clinical training to support one-on-one patient interactions
 2. Valid credentials
 3. Interdisciplinary team work training (should be aligned with team based training for comprehensive care team)
- The pharmacist conducts the initial consult in person⁸⁶.

3. Develop 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 as needed or requested by the patient
- To develop the person-centered medication action plan the pharmacist will:
 - Create a comprehensive list of all patient medications including currently prescribed medications and any nonprescription nutritional supplements, vitamins, and over-the-counter medications
 - Assess each medication for appropriateness, efficacy, safety, compatibility, ease of use, and adherence for a patient’s medical condition and co-morbidities.
 - This assessment will be person-centered and also take into account the individual’s cultural traditions, personal preferences and values, home or family situation, social circumstances, age, functional deficits, health literacy, medication 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:

⁸³ 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.

⁸⁴ 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

⁸⁵ Pharmacist should have some experience in a direct patient care role, and training should occur at on-boarding with additional team based training as needed (i.e.; new team members join, protocols change, etc.) and annual validation of credentials.

⁸⁶ 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 MTM.

- An updated and reconciled medication list with information about medication use, allergies, and immunizations
- Process to engage patients and their caregivers on better therapeutic management techniques in line with reported self-management goals
- Documentation of actionable medication management recommendations that are communicated to patients, caregivers, and all of their health care providers
- The pharmacist's 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
- An outline of the duration of the intervention, frequency of touchpoints throughout the intervention, and instructions on follow-up with the pharmacist, comprehensive care team, primary care team, and specialists as needed⁸⁷.
- Specifications of when touchpoints should occur and which members of the care team should be involved
- 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 and primary care provider but which should also be guided by patient preference and the team needs assessment⁸⁸.
 - Developing technological capabilities for specified individuals to have access to the person-centered medication action plan

4. Implementation of person-centered medication action plan with revisions as necessary

- The pharmacist and care team initiate touchpoints with the patient and/or caregiver as outlined in the person-centered medication action plan⁸⁹
 - 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 revisit and adjust person-centered medication action plan as necessary after follow up visits with the care team and referral

⁸⁷ 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.

⁸⁸ If the patient has a comprehensive care team or is working with a Community Health Worker, those individuals should also have access.

⁸⁹ 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.

Appendix B: Definitions

Community Health Worker: A frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery

Comprehensive Behavioral Health Assessment: An assessment that screens for behavioral health, substance abuse, and trauma and is delivered by a licensed clinical professional

Medicaid Health Home: An optional Medicaid state plan benefit for states to establish Health Homes to coordinate care for people with Medicaid who have chronic conditions...CMS expects states health home providers to operate under a “whole-person” philosophy. Health home providers will integrate and coordinate all primary, acute, behavioral health, and long-term services and supports to treat the whole person

Natural Supports: Can include but is not limited to family, clergy, friends and neighbors

Peer Support Specialist: Provides counseling and support services to an individual

Person-Centered: The individual self-determines and identifies their natural supports, which may include but is not limited to family, clergy, friends and neighbors and chooses whether to involve them in their medical care planning. The individual actively makes all decisions about their care plan and treatment. Person-centered care focuses on the individual’s values, belief, preferences, and needs, and ensures that these factors guide all clinical decisions as well as non-clinical decisions that support independence, recovery and quality of life.

Person-Centered Assessment: An assessment that will evaluate the person’s historical and current needs while considering the individual’s cultural traditions, personal preferences and values, family situations, social circumstances and lifestyles

Person-Centered Care Coordination Plan: A care plan used by the comprehensive care team that is developed with consideration for the individual’s cultural traditions, personal preferences and values, family situations, social circumstances and lifestyles as well as their strengths.

Predictive Modeling: A set of criteria (e.g.; diagnoses, demographics, procedures, service history, prescription drugs, etc.) that is used to predict potential of future risk for the types of health care outcomes that are trying to be prevented (e.g.; unnecessary service utilization and costs).

Risk Stratification: The separation of a population into sub-populations based on a set of risk criteria. In this case the risk criteria being considered is around what makes an individual complex, as defined by the Practice Transformation Taskforce. The PTF definition of complex is: Individuals who have either multiple complex medical conditions, multiple detrimental social determinants of health, or a combination of both that contribute to preventable service utilization and poorer overall healthcare management that ultimately negatively impacts the Individual’s overall health status.

Shared Savings Program: A form of a value based payment that offers incentives to provider entities to reduce healthcare spending for a defined patient population by offering physicians a percentage of the

net savings realized as a result of their efforts. Savings are typically calculated as the difference between actual and expected expenditures and then shared between payer and providers.

Super-Utilizer: Individuals whose complex physical, behavioral, and social needs are not well met through the current fragmented health care system. As a result, these individuals often bounce from emergency department to emergency department, from inpatient admission to readmissions or institutionalization – all costly, chaotic, and ineffective ways provide care and improve patient outcomes

Value Based Insurance Design: Insurance plans with structural components that incent patients to engage in healthy behavior, participate in their healthcare decisions, and make intelligent use of healthcare resources.

Value Based Payment Design: Form of payment that holds physicians accountable for the cost and quality of care they provide to patients. This differs from the more traditional fee for service payment method in which physicians are paid for volume. The goal of value based payments is to reduce inappropriate care and reward physicians, other healthcare professionals and organizations for delivering value to patients. Examples of value based payments include shared savings programs (SSPs).

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Appendix C: Sample Tools

Complex Patient Criteria Examples:

Camden Coalition Care Management Triage (<https://www.camdenhealth.org/wp-content/uploads/2012/10/CCHP-care-management-triage-current.pdf>)

Camden Coalition Pre-Enrollment Form – with risk stratification (<https://www.camdenhealth.org/wp-content/uploads/2012/10/CCHP-pre-enrollment-bedside-intake.pdf>)

Needs Assessment Examples

Camden Coalition Care Management Enrollment Intake (<https://www.camdenhealth.org/wp-content/uploads/2012/10/Enrollment-Intake14July2014.pdf>)

Care Plan Examples

Camden Coalition Care Plan (<https://www.camdenhealth.org/cross-site-learning/resources/care-interventions/care-management-information/>)

Kansas Medicaid Health Home Action Plans
(http://www.kancare.ks.gov/health_home/providers_forms.htm)

Readiness to Transition to Self-Directed Care Examples:

The Client Perception of Care Questionnaire (CPCQ) (<https://www.camdenhealth.org/wp-content/uploads/2012/10/CCHP-CPCQ-for-pre-enrollment-and-graduation.pdf>)

Oral health risk assessment: <http://www.astdd.org/basic-screening-survey-tool>

Oral Exam Example:

Oral Health Assessment Tool (OHAT) for Dental Screening
modified from Kayser-Jones et al. (1995) by Chalmers (2004)

Patient: _____		Completed by: _____		Date: ____/____/____
<p>Scores: The final score is the sum of scores from the eight categories and can range from 0 (very healthy) to 16 (very unhealthy). While the cumulative score is important in assessing oral health, the score of each item should be considered individually. Symptoms that are underlined require immediate attention.</p> <p>*If any category has a score of 1 or 2, please arrange for the patient to be examined by a dentist.</p>				
Category	0 = healthy	1 = changes *	2 = unhealthy *	Category scores
Lips	Smooth, pink, moist	Dry, chapped, or <u>red at corners</u>	Swelling or lump, <u>white/red/ulcerated patch</u> ; <u>bleeding/ulcerated at corners</u>	
Tongue	Normal, moist, roughness, pink	Patchy, fissured, red, coated	Patch that is <u>red and/or white, ulcerated, swollen</u>	
Gums and tissues	Pink, moist, smooth, no bleeding	Dry, shiny, rough, red, swollen, one <u>ulcer/sore spot under dentures</u>	<u>Swollen, bleeding gums, ulcers, white/red patches, generalized redness or ulcers under dentures</u>	
Saliva	Moist tissues, watery and free-flowing saliva	Dry, sticky tissues, little saliva present	<u>Tissues parched and red, very little/no saliva present, saliva very thick</u>	
Natural teeth Yes/No	No decayed or broken teeth/roots	<u>1-3 decayed or broken teeth/ roots</u> or teeth very worn down	<u>4 or more decayed or broken teeth/roots, or fewer than 4 teeth, or very worn down teeth</u>	
Dentures Yes/No	No broken areas or teeth, dentures regularly worn	1 broken area/ tooth or dentures only worn for 1-2 hrs daily, or loose dentures	<u>More than 1 broken area/tooth, denture missing or not worn, needs denture adhesive</u>	
Oral cleanliness	Clean, no food particles or tartar in mouth or on dentures	Food particles/ tartar/ plaque in 1-2 areas of the mouth or on small area of dentures or bad breath	Food particles/tartar/plaque in most areas of the mouth or on most of dentures or severe halitosis (bad breath)	
Dental pain	No behavioral, verbal, or physical signs of dental pain	Verbal &/or behavioral signs of pain such as <u>pulling at face, chewing lips, not eating, aggression</u>	Physical signs such as <u>facial swelling, sinus on gum, broken teeth, large ulcers, and verbal and/or behavioral signs such as pulling at face, chewing lips, not eating, aggression</u>	
<input type="checkbox"/> Arrange for patient to be examined by a dentist. <input type="checkbox"/> Patient or family/guardian refuses dental treatment. <input type="checkbox"/> Review this patient's oral health again on (date): ____/____/____				TOTAL SCORE: <u>16</u>

Chalmers J, Johnson V, Tang JH, Titler MG. Evidence-based protocol: oral hygiene care for functionally dependent and cognitively impaired older adults. *J Gerontol Nurs.* 2004 Nov;30(11):5-12.

Oral Health Training & Education:

- Smiles for life curriculum: free online education resource that provides continuing medical education (CME) credits (<http://www.smilesforlifeoralhealth.org/buildcontent.aspx?tut=555&pagekey=62948&cbreceipt=0>)
- Medications that cause dry mouth: https://www.ctdhp.com/providers_items.asp?a=3&b=38
- IPE Toolkit (see below)

Smiles for Life Interprofessional Education (IPE) Tool Kit

Resource	Description	Link
Core Competencies for Interprofessional Collaborative Practice (2011)	A report of an Expert Panel on core competencies for interprofessional collaborative practice for health professionals as integral to safe, high quality, accessible, patient-centered care	www.aacn.nche.edu/education-resources/ipecreport.pdf
Education to Practice Tool Kit	A comprehensive reference that contains a collection of tools that may be used to implement an interprofessional initiative in a clinical or educational setting	http://education2practice.org/toolkit.php
MedEdPORTAL iCollaborative	iCollaborative is a service of MedEdPORTAL that provides a platform for educators and learners to share educational innovations for health professions	www.mededportal.org/icollaborative/
World Health Organization (WHO)	Framework for Action on Interprofessional Education & Collaborative Practice provides strategies to help health policy-makers and educators implement interprofessional education and collaborative practice	http://whqlibdoc.who.int/hq/2010/WHO_HRH_HPN_10.3_eng.pdf
National Center for Interprofessional Practice and Education	National Center provides resources for leadership and scholarship to advance interprofessional education and practice for improving quality, outcomes and cost of health care	http://nexusipe.org
Center for Innovation in Interprofessional Education (UCSF)	Mission is to support the creation, implementation and evaluation of interprofessional education to enhance collaborative practice and	http://interprofessional.ucsf.edu

	improve health and wellbeing	
Center for Health Science Interprofessional Education, Research and Practice (University of Washington)	Promotes IP education and collaborative practice curriculum and innovations, provides infrastructure for training initiatives, and conducts evaluative research regarding the impact of IP innovations	http://collaborate.uw.edu

INTERNATIONAL IPE WEBSITES

American Interprofessional Health Collaborative	www.aihc-us.org
Australasian Interprofessional Practice & Education Network	www.aippen.net
Centre for the Advancement of Interprofessional Education	http://caipe.org.uk
Canadian Interprofessional Health Collaborative	www.cihc.ca
Nordic Interprofessional Network	http://nipnet.org
PRONTO International	http://prontointernational.org

Appendix D: Interview List

Interviewee(s)	Topic(s)
Pat Baker & Elizabeth Kraus, Connecticut Health Foundation	<ul style="list-style-type: none"> Measuring Health Equity Gaps Community Health Workers
Bernadette Keleher	<ul style="list-style-type: none"> Community Linkages
Bruce Gould and Petra Clark <u>Dufner</u> , UCONN Health/AHEC	<ul style="list-style-type: none"> Community Health Workers
Camden Coalition	<ul style="list-style-type: none"> Community Health Workers Identification of complex patients
Terri DiPietro, Middlesex	<ul style="list-style-type: none"> Identification of complex patients
Suzanne Lagarde, CEO Fair Haven Community Health Center	<ul style="list-style-type: none"> E-consults
Steve Ruth, Systems and Management Consulting	<ul style="list-style-type: none"> Care Transitions
Primary Care Coalition of Connecticut	<ul style="list-style-type: none"> Identification of complex patients Community Linkages Care Transitions
Grace Damio, Hispanic Health Council, Director of Research and Training	<ul style="list-style-type: none"> Community Health Workers
Dawn Lambert & Kate McEvoy, DSS	<ul style="list-style-type: none"> Long Term Support Services
Daren Anderson, Community Health Center, Inc.	<ul style="list-style-type: none"> E-consults
Molly Gavin, CT Community Care, Inc.	<ul style="list-style-type: none"> Long Term Support Services
Center for Healthcare Strategies	<ul style="list-style-type: none"> Identification of complex patients Identification of equity gaps Dynamic Clinical Care Teams Community Health Workers Community Linkages
CT SIM State Program Experience (CMMI Support)	<ul style="list-style-type: none"> All

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