

CONNECTICUT
HEALTHCARE
INNOVATION PLAN



MAPOC Care Management Committee

Practice Transformation
Taskforce CCIP Standards
Review

September 22, 2015

Topics for Today's CCIP Review to the MAPOC CMC

1. **Review feedback & CCIP changes** since the last presentation to the MAPOC CMC
2. **Review current set of standards** to get additional input from MAPOC CMC members and answer questions
3. **Provide information** on CCIP next steps

Overview of changes

4 main developments since the last meeting

- **Care Transitions** – embedded care transitions functions into the existing standards based off of feedback
- **eConsults** – reviewed eConsults best practices and addressed concerns related to person-centeredness and process
- **Community Consensus / Community Health Boards** – clarified the long-term role and function of local community health boards with possible care transitions functions; considering with DPH connection to SIM population health planning
- **Language & Definitions** – focusing language on person-centeredness and clarifying/updating definitions

CCIP Network Participation

- To be eligible for CCIP technical assistance support, the Advanced Network or FQHC must be participating in the Medicaid Quality Improvement and Shared Savings Program (MQISSP)
- The MQISSP RFP process will include a commitment to participate in CCIP and meet CCIP requirements
- Although the MQISSP RFP will be used to identify CCIP participants, CCIP capabilities will be “payer agnostic”...they will apply to all patients regardless of who their insurer is (i.e. Medicare, Medicaid, commercial)

Design Programs: Complex Individuals

Complex Patient Intervention Objective

Intended to provide intensive care management to 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.

Intervention Highlights

- Complex individuals will be **identified** through risk stratification that considers **clinical**, **behavioral**, and **social** risk factors
- Individuals with complex needs will be connected to a **Comprehensive Care Team (CCT)** to receive more intensive care management support
- The CCT will include a **Community Health Worker** to provide community focused care **coordination with social services** and to provide **culturally and linguistically aligned self-care management education**. Additionally there will be a **case manager**, a **clinically focused care coordinator**, and a **CCT manager**
- The CCT will also have access to a **licensed behavioral health specialist** to address behavioral health needs of complex individuals

Design Programs: Complex Individuals

Intervention Highlights

- The network will conduct a **root cause analysis** among their complex patient population to identify and implement additional interventions to the CCT and/or additional CCT team members that may be beneficial
- The CCT will perform a **person-centered needs assessment** that will inform a **person-centered care coordination plan** to support the individual to reach his/her clinical, social, and behavioral treatment goals
- The individual will be **transitioned to self-directed care management** when the CCT and individual feels ready
- There will be processes in place to **monitor transitioned patients** for the need to reconnect post-transition

Design Programs: Equity Gaps

Equity Gap Intervention Objective

Identify and provide culturally and linguistically appropriate support to sub-populations, defined by a large race and ethnic backgrounds, that in aggregate are experiencing poorer health outcomes as compared to other sub-populations. The goal of this programs is to identify individuals within the sub-population who would benefit from more culturally and linguistically appropriate care.

Intervention Highlights

- The CCIP equity gap program will include two elements – 1) standards on how to do **health equity continuous quality improvement**; and 2) standards for an **intervention to address identified equity gaps**
- The **continuous quality improvement** standards provide guidance on how to routinely capture and analyze data to **identify health care disparities at a population level**
- The intervention standards provide guidance on how to **standardize certain care processes to make them more culturally and linguistically appropriate** and offering the **support of a Community Health Worker to those who will benefit** from more culturally supportive care

Design Programs: Equity Gaps

Intervention Highlights

- The CHW will be trained to offer culturally and linguistically appropriate **education specific to the patient's clinical area of need** (e.g.; diabetes) and on **better self-care management skills**.
- The CHW will collaborate with the patient to **develop a person-centered self-care management plan** that reflects the patients cultural needs, personal preferences, values, strengths and **readiness to change**.
- The networks will monitor the equity gap intervention for **effectiveness** through monitoring **quality** and **patient experience** metric

Design Programs: Behavioral Health Integration

Behavioral Health Integration Intervention Objective

The Behavioral Health Integration standards are intended to improve the ability of primary care practices to identify and treat behavioral health needs either within the primary care setting or to make, confirm, and close the communication loop on a referral when necessary

Intervention Highlights

- The networks will incorporate the use of a screening tool to screen all patients for mental health, substance abuse, and trauma needs
- When a behavioral health need is identified the primary care providers will determine in collaboration with the patient if they want/can be treated in the primary care setting or would prefer/need a referral
- Networks will develop an MOU with at least one behavioral health provider to support the facilitation and accountability for the referral process
- Processes and protocols will be developed in partnership with behavioral health providers to facilitate referral tracking, follow up, and ensuring that the behavioral health care plan is shared with primary care when a referral is made
- Provision of appropriate behavioral health training on promotion, detection, diagnosis, and referral for treatment for primary care practice

Design Programs: Community Consensus & Linkages

Shared Governance Objective

Development of Advanced Network and FQHC linkages to community resources is a key component of the CCIP. Because many of the needed community resource providers are resource, capacity, and geographically constrained the PTF is recommending convening community stakeholders to establish local Community Health Board Collaboratives. To better integrate social services. The shared governance will be developed by the technical assistance vendor in the service areas where there are Advanced Networks and/or FQHCs participating in CCIP with the involvement of the CCIP participants and other key healthcare stakeholders to be transitioned to local Community Health Boards.

Intervention Highlights

- The Community Health Boards will be the primary vehicle of the community consensus work.
- To establish the Community Health Boards the technical assistance vendor will convene healthcare stakeholders from across the healthcare continuum and relevant community stakeholders
- The stakeholders convened will be representative of the community being served and has to include consumer representation
- The community collaborative will be responsible for establishing protocols and processes for network linkages to shared resources in the community and can serve as a resource for determining additional community needs (e.g.; transitions from hospitals to home)
- Prioritization of the linkages established will be informed by an assessment of the communities needs and resources conducted by the community collaborative

Design Programs: Oral Health Integration

Oral Health Integration Intervention Objective

Improve dental and overall health for all populations through providing oral health prevention in the primary care setting and forming stronger linkages between primary care and oral health providers. It is well acknowledged that there is an oral/systemic link. An individual's oral health can impact their overall health and vice versa, in particular when individuals have chronic conditions like diabetes.

Intervention Highlights

- The networks standardize care processes to routinely do an oral health screening and exam
- The appropriate primary care providers are trained to provide preventive care within the primary care setting
- The practice will develop resources and processes/protocols to make, manage, and close out dental referrals with a preferred dental network for individuals who do not have a regular source of dental care
- The network and the preferred dental network establish technology to support communication of the relevant care information between primary care and dental providers

Design Programs: eConsults

eConsults Intervention Objectives:

Improve timely access to specialists, improve PCP and specialist communication, and reduce downstream costs through avoiding unnecessary in-person specialist consultations. eConsults will facilitate this through providing primary care providers the means to seamlessly consult electronically with specialists prior to referring a patient for a face to face consult.

Intervention Highlights

- The networks will **elect one specialty area to do eConsults** – common areas include cardiology and dermatology
- **A specialist practice/providers will be identified** either within or outside the network, depending on the Advanced Network/FQHCs physician make up, with which to **establish eConsult protocols**
- The designated specialists reviewing eConsults will determine 1) if **a face to face is needed**; 2) if **more information on the patient is needed** before a determination about a face to face consult can be made; or, 3) A **face to face consult is not needed** and a **consult note is provided** from the specialist to the primary care provider on how to care for the patient in the primary care setting
- The networks will have to establish a **reimbursement mechanism** for eConsults

Design Programs: Medication Therapy Management

Medication Therapy Management Objective

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. This intervention will be an elective CCIP capability for patients with complex therapeutic needs who would benefit from a comprehensive personalized medication management plan. This intervention is designed 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

Intervention Highlights

- The networks develop processes to assess the risk of a patient's pharmacy regimen.
- The networks design a pharmacist integration model that aligns with their needs and capacity
- The pharmacist integrates with the care team and provides MTM services
- The medication action plan is person-centered and addresses medical issues such as appropriateness, efficacy, and safety as well as socio-economic issues such as affordability, cultural traditions and lifestyle
- MTM is a fluid process that includes follow-up and subsequent touch points with the patient
- The medication action plans becomes part of the medical record and becomes part of the care conferences regarding patient progress

CCIP Next Steps

Next Steps

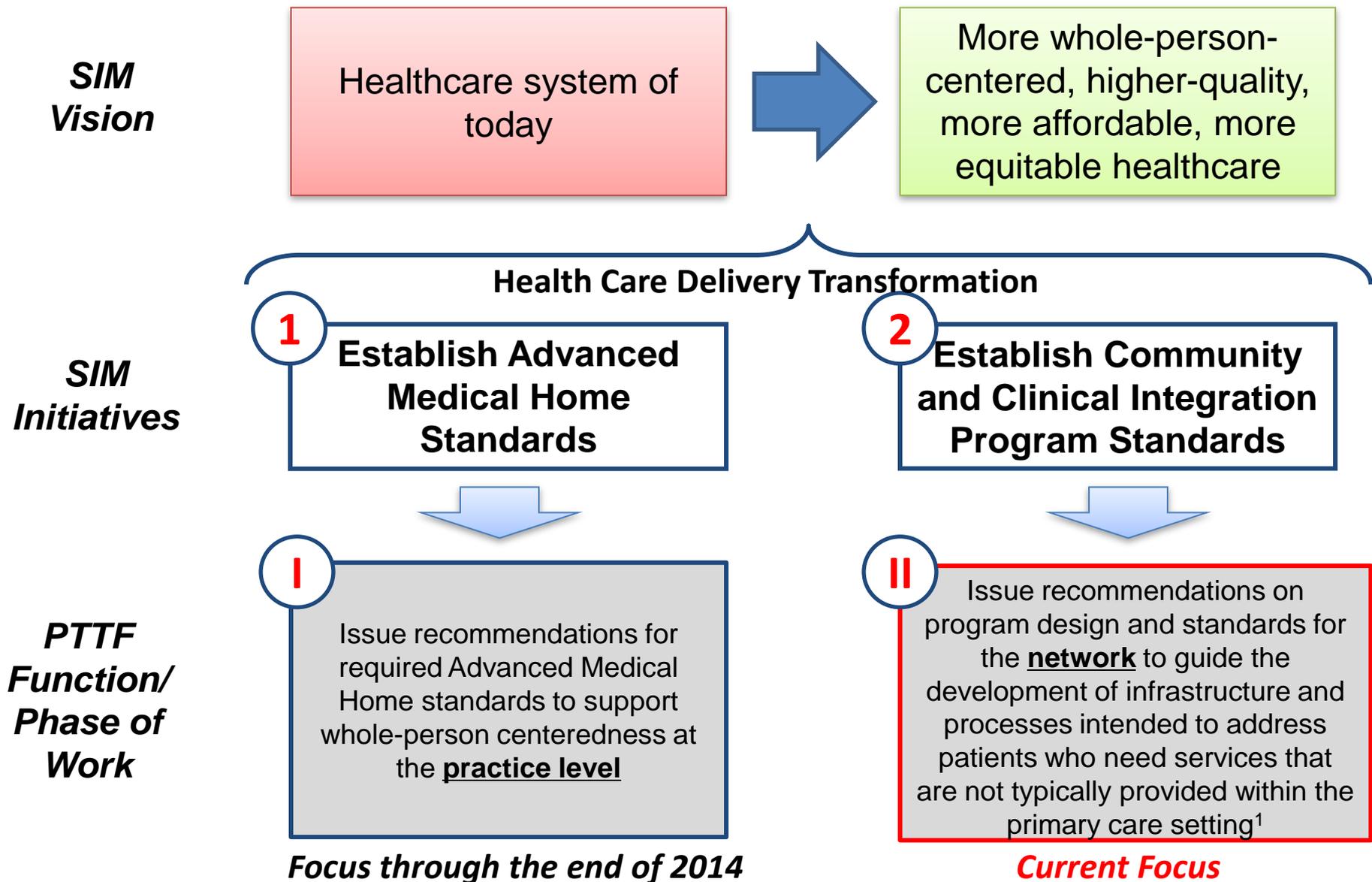
- Consider feedback to incorporate into report until 9/24
 - Comments to be posted online with a FAQ review
- Final review of CCIP report with PTF on 9/29
- Disseminate final CCIP report to HISC on 10/2
- Present the final CCIP report and standards to HISC on 10/8
- Provide CCIP standards to DSS by 10/12

Questions? Discussion?



Additional Slides & Context

PTTF's Charge in the Context of SIM



Notes:¹ This could include specialists that are 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)

Care Transitions Objective

The care transitions intervention will develop methods to improve communication and the exchange of patient health information when transitioning between settings in order to improve patient outcomes by ensuring that patients are safely transitioned with self-management tools to implement their plan of care.

To Note

The feedback received to date on these guidelines questions whether our objective for this standard may be better served by embedding the components of this intervention in the shared governance and patients with complex conditions standards. Commenters have noted that many elements of the guidelines are hospital-centric and embedded in other processes. As most MQISSP members may not have member hospitals, it might be more effective to address quality transitions of care through other approaches.

Intervention Highlights

- Networks **assess a patient's appropriateness for more structured care transitions**
- Patients are designated into **tiers corresponding to acuity and socio-economic factors**
- All patients receive **a person-centered, standardized care transitions plan** that includes instructions for follow-up and appointments made pre-discharge
- Depending on the tier, **patients receive a series of follow-up interactions** including in-home visits for most complex patients and telephonic or telehealth interactions for others
- Networks can use a **variety of means to implement the person-centered care transitions plan** and **to engage the patient with tools designed to improve self-management skills**

CCIP's Charge in the Context of SIM

The CCIP will address the needs of more complex patients and patients currently experiencing gaps in care who need access to clinical services that may not reside within the network (e.g.; behavioral health) and community support services that help to address social barriers to care.

AMH Standards promote:

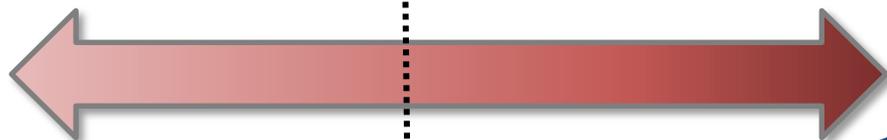
- A comprehensive care assessment (Standard 3, Element C)
- A care plan that addresses needs (Standard 2, Element A)
- Provision of team based care to execute plan (Standard 2, Element D)



This will place patients on a continuum of care based on their health status

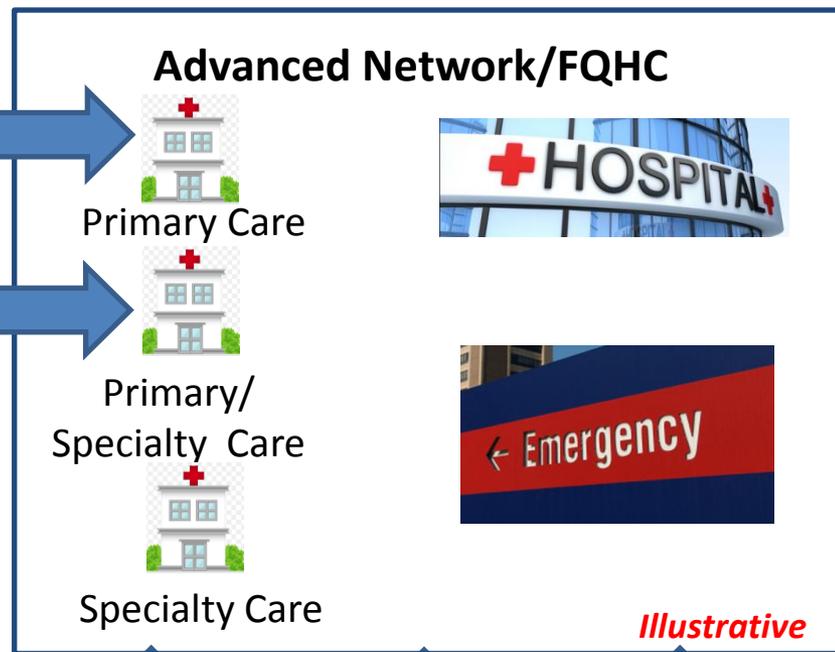
Good Health

Poor Health

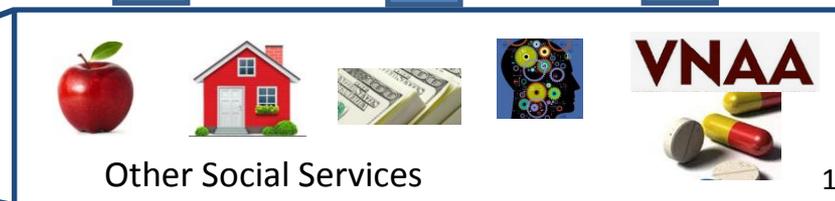


Needs met within primary care practice

More intensive care needs that cannot be met by the primary care practice



CCIP will create standards to integrate needed services into the network



CCIP Approach

A review of existing programs with similar objectives to CCIP suggested there are three guiding principles that should govern the program design.

CCIP Guiding Principles

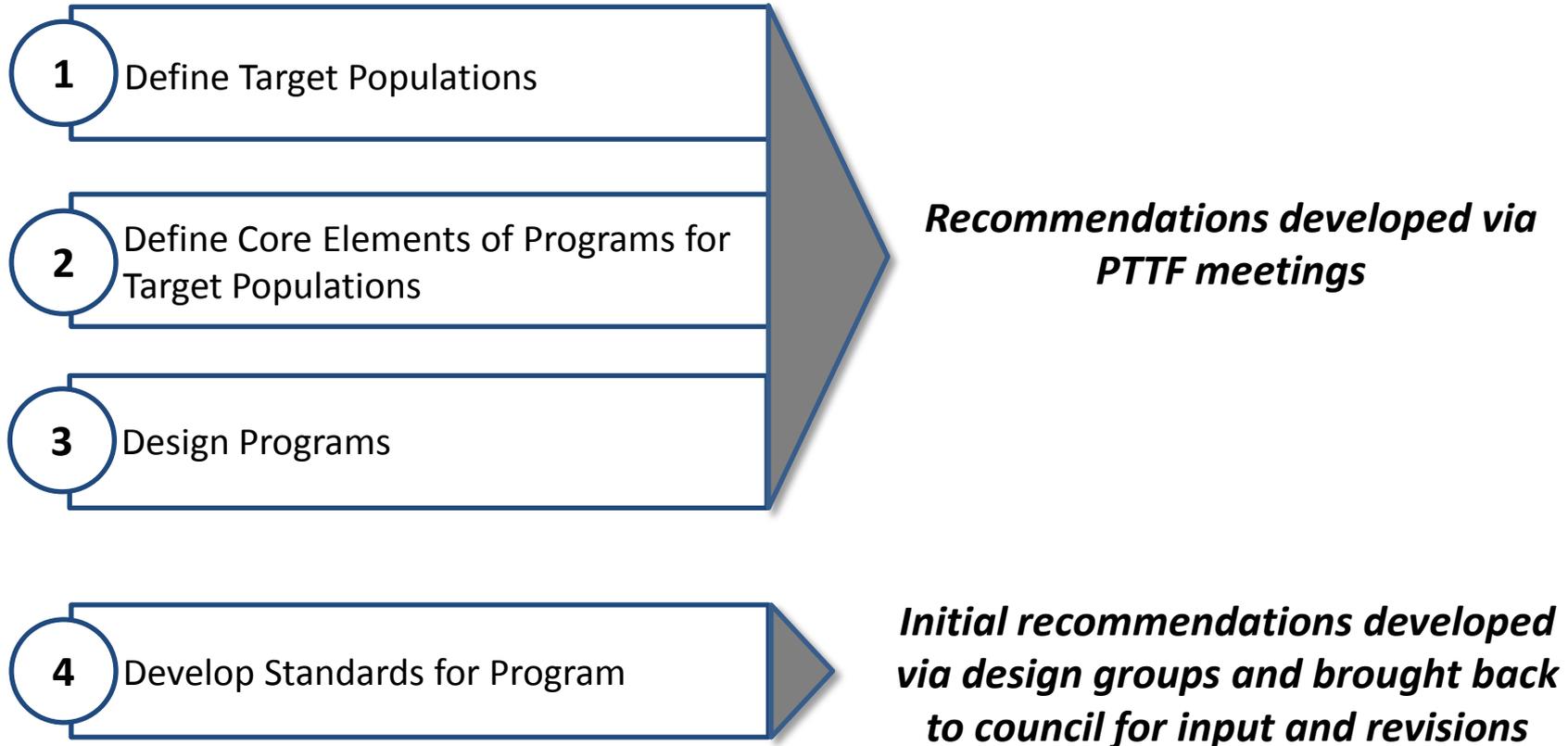
CCIP Objective:

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

- 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**

CCIP Design Process

To achieve the first guiding principle, whole-person centeredness, the PTF agreed that the CCIP programs should be designed around the needs of target populations.



Guiding principles two and three will be achieved through the more detailed design components (step 4)

CCIP Design Process

Design Group 1

This group is focusing on developing standards for the clinical capabilities

Design Group 2

This group is focusing on developing standards for linkages that will be formed outside the network – this includes developing a governance structure that promotes accountability amongst partners for 1) providing agreed upon services and, 2) improving patient outcomes



Will Fulfill Guiding Principle 3

Design Group 3

This group is focusing on developing standards around the analytic methods for identifying target populations, technology to support seamless communication between care team members and community partners, and defining how to measure and report on program performance

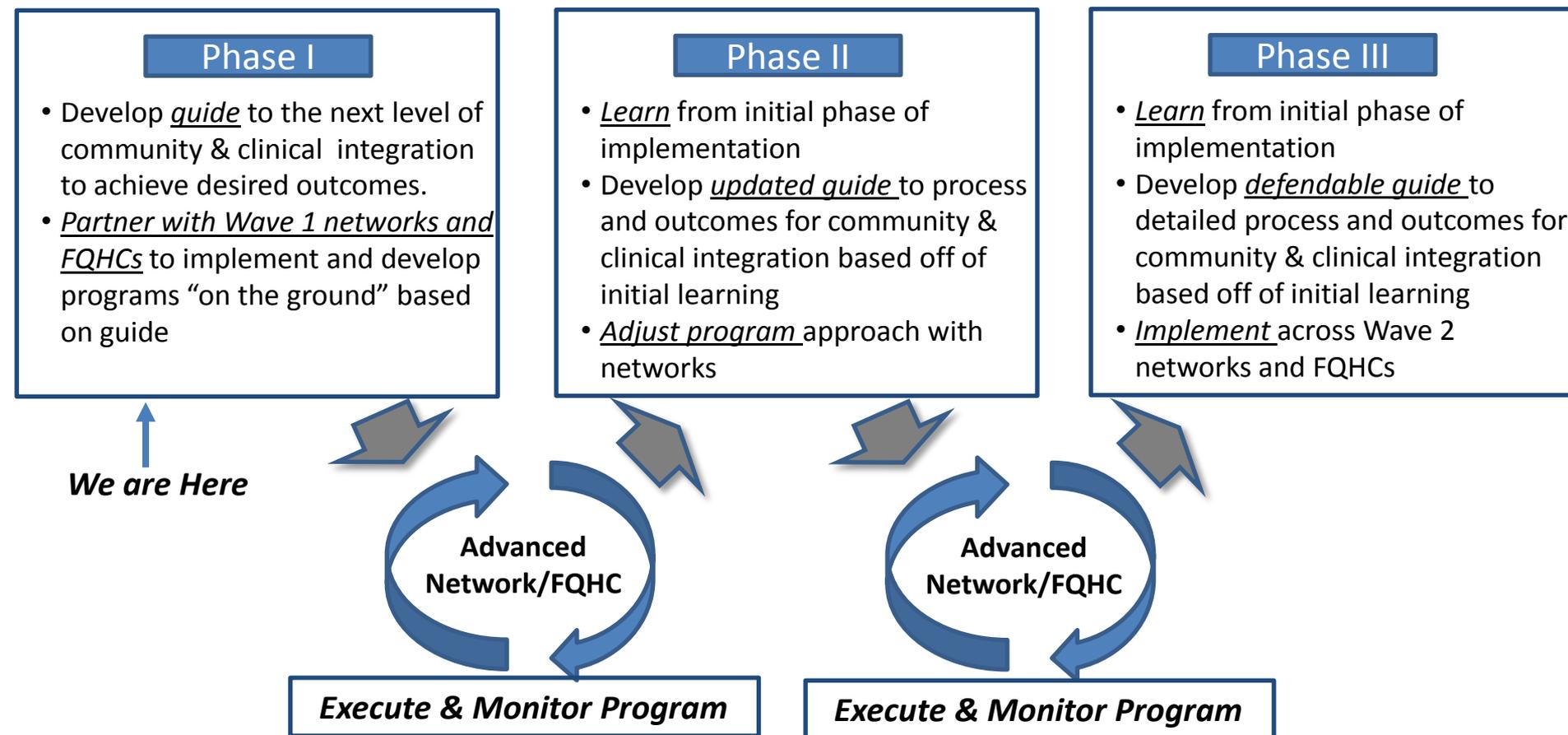


Will Fulfill Guiding Principle 2

Conversations started with HIT to support CCIP needs

CCIP Design Considerations

The PTF recognizes that integrating community and clinical services at the network level is innovative and will require an iterative design process. Thus, in making recommendations the PTF has sought to allow innovation around specific design details while providing standardization on implementation guidelines at a high level across networks.



Define Target Populations

The PTTF wanted to strive for a level of standardization while also allowing flexibility for Advanced Networks and FQHCs to implement a program that best suits their population's needs in order to ensure whole-person centeredness.

The PTTF agreed that Advanced Networks and FQHCs should have the freedom to choose the population they want to focus on, but the CCIP recommendations will broadly define three population types.

This will promote:

- *A standardized CCIP approach across Advanced Networks and FQHCs*
- *Addressing known needs of Connecticut patients*
- *Alignment with overall CCIP and CT SIM goals*



The target populations could be:



**Complex Individuals
(clinically and socially)**

- Reduce readmissions and ASC admissions, ED use



**Populations Experiencing
Equity Gaps**

- Reduce health equity gaps



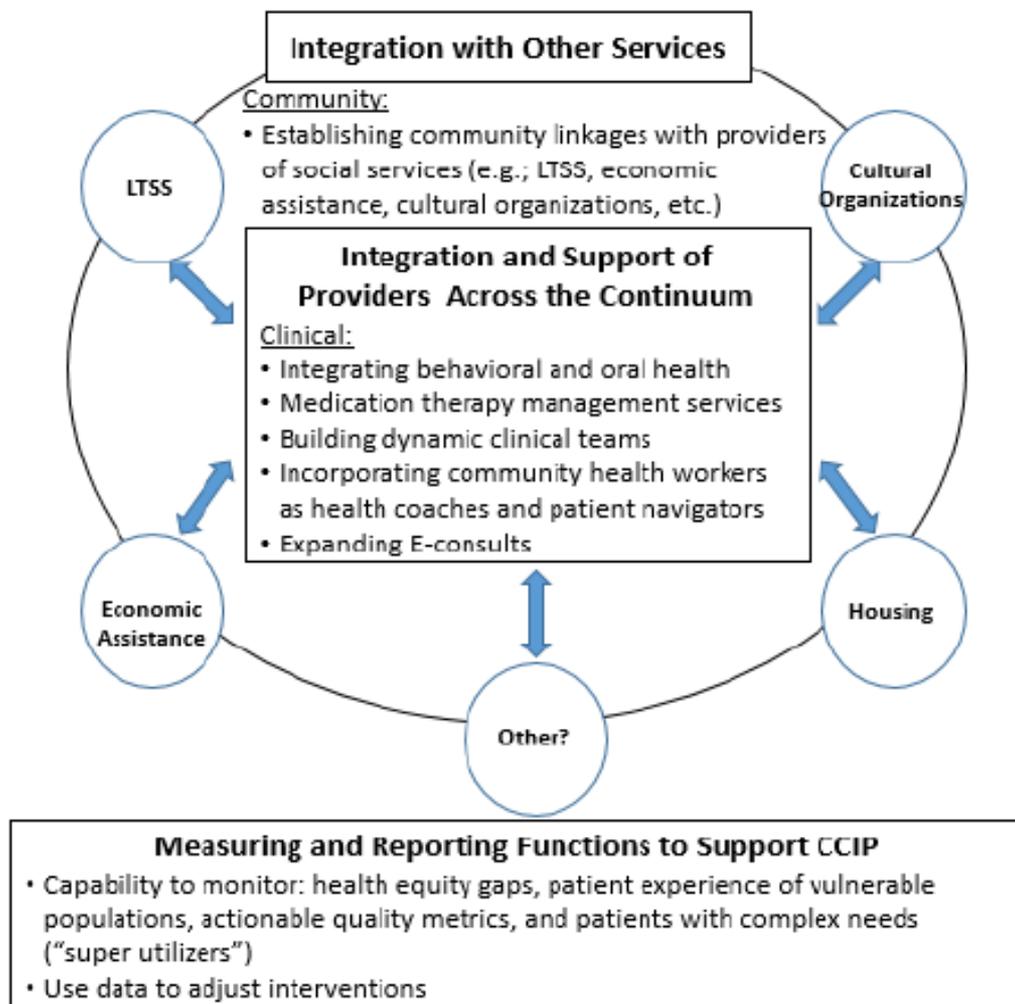
**Behavioral
Health**

- PCMH CAHPS
- BH access
- BH screening/depression remission

Focus Today will be on Complex Patients to Provide an Example of the Direction the PTTF is going with the CCIP Recommendations

Define Core Elements of CCIP Programs

In considering which elements should be core to the CCIP program design, the PTF considered the set of 11 capabilities intended to improve clinical and community integration identified in the CT SIM grant.



Capabilities Were Evaluated Through.....

- Subject Matter Expert Interviews
- Interviews with leadership running programs with similar objectives nationally and locally
- Review of literature on effectiveness of capabilities
- CMMI Technical Assistance
- Soliciting input from key stakeholder groups (e.g.; Primary Care Coalition of CT)

Define Core Elements of CCIP Programs

The evaluation of the 11 capabilities revealed a set of capabilities that were consistently used to address target population needs. The PTF agreed to define these capabilities as core to the CCIP programs and the remaining and some additional capabilities as elective.

Core



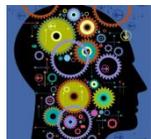
**Complex Individuals
(clinically and socially)**

Comprehensive Care Team + *CHW*
Community and Clinical Linkages



**Populations
Experiencing
Equity Gaps**

CHW + *Community and Clinical
Linkages*



**Behavioral
Health**

*Behavioral Health Integration
(screening, integrated BH care or referral to BH provider,
confirm linkage to provider, follow-up)*

Medication Therapy Management

E-Consult

Oral Health

Care Transitions

Elective

3 Design Programs

To improve care for the individual patients in the target population, complex patients or patients experiencing equity gaps, a general process improvement approach was employed that draws on tools commonly used to evaluate and improve patient care.

