



September 25, 2015

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SUBJECT: Draft CCIP Report

Dear Mark:

We appreciate the opportunity to submit comments to the SIM Program Management Office about the Draft Community and Clinical Integration Program (CCIP) Report. We support the 11 capabilities set forth in the Connecticut SIM grant that networks could implement to support better community and clinical integration. CHA would like to offer the following comments:

Appendix A: Community and Clinical Integration Program Standards

Target Population: Complex Patients

CHA commends the person-centered approach that is the core philosophy of the Plan but encourages that the role of the caregiver be more strongly emphasized as a member of the comprehensive care team. Working collaboratively with patients, family, and friends is an effective way to help patients understand physicians' instructions, especially when they may be in a state of discomfort, pain, or fear, or in declining health. The Plan should include the recognition that knowledge and information will be freely shared between and among patients, care partners, physicians, and other caregivers, as designated by the patient. For certain populations, a family-centered approach to care delivery may support the patient more holistically. CHA also recommends that the Plan acknowledge the time and support that will be required for patients, caregivers, and their providers to engage in the necessary education and training that will be needed as they become active and engaged partners in their care and decision-making.

CHA recommends that the Plan clearly describe and outline the target population and complex patient definition. Defining medical complexity is multi-factorial and should include severity of the illness, degree of impairment or disability, and level of need for comprehensive care management. It is important to note that conditions may be serious and complex for some patients at some points during the course of their disease or disability. [The Institute of Medicine](#) states that serious and complex medical conditions should reflect the characteristics of the management of the condition rather than some inherent biological complexity, such as:

- Conditions that are life threatening.
- Conditions that cause serious disability without necessarily being life threatening.
- Conditions that cause significant pain or discomfort that can cause serious interruptions to life activities.
- Conditions that require major commitments of time and effort from caregivers for a substantial period of time.

- Conditions that may require frequent monitoring.
- Conditions that predict or are associated with severe consequences.
- Conditions associated with negative consequences for someone else.
- Conditions that affect multiple organ systems.
- Conditions that require management to "tight" physiological parameters.
- Conditions whose treatment carries a risk of serious complications.
- Conditions requiring adjustment in a "nonmedical environment."

Clear definitions and guidance would support providers in assessing patient complexity in a common manner. Additionally, the Plan should have a mechanism by which providers can provide subjective data based on their experience with the patient.

Additionally, the Plan discusses the role of the Community Health Worker (CHW) at some length. This function and unique skill set is envisioned as a critical member of the team and an important factor in successful practice transformation. However, the role of the CHW is fairly new and not yet widespread, and there appears to be a lack of current standards with regard to qualifications, training, specific functions performed, as well as a defined tool kit of interventions. The activities associated with the function are described broadly – home visits, education, connecting to community resources, assessments – but if we aspire to track and understand the impact of the CHW role, we should proactively implement the foundations for measurement. In related disciplines such as case management and disease management, methods already exist to capture what those functions do, standardize data to some extent, and attribute value to said activities.

We suggest that it will be important to understand the functions, interventions, and results related to the CHW role and begin to develop an evidence base that will guide the evolution of, and investment in, the role. This will require tools, technology, training, standardization, and measurement. CHA recommends the creation of a Measurement Committee to define a minimum set of standardized information to be captured across practices and systems, and a determination of key performance indicators.

Initially, this may include developing a set of standard interventions for CHWs, related codes/terminology, and data entry/capture guidelines in the early stages to enable statewide tracking and comparisons. In the later stages, the Measurement Committee could guide more complex endeavors such as running regression models to analyze what makes some CHWs more successful than others and assessing whether certain combinations of CHW characteristics (like race, education, etc.) predict success with specific patient cohorts.

Such a committee or work group supporting the Practice Transformation Task Force could also address other topics like the integration, standardization, and mining of data collected via the various behavioral health assessment tools discussed in the recommendations, and the measurement and analysis of e-consult volume, cost, and effectiveness versus traditional visits.

Additionally, CHA would like to note the importance of the Community Care Team – integrated teams of hospital representatives and community partners who work together to address a patient's needs holistically.

Health Equity: Continuous Quality Improvement Standards

CHA commends the Plan for including standards to support continuous quality improvement. CHA recommends that participating providers receive access to training and resources to support them in their quality improvements efforts. Participating providers should be familiar with the science of improvement, change management, and performance measurement. CHA recommends that participating providers receive credit for testing interventions utilizing cycle of change methodology (i.e., PDSA) to assess the effectiveness of an intervention prior to implementing, or spreading, the change. Providers should be given the necessary time to test adequately interventions prior to implementing change. CHA recommends that testing a cycle of change be included in Section 3, and that at least one CHW is included in the Quality Improvement team that conducts the cycle of change. There are quality improvement resources available from the American Hospital Association, the Centers for Medicare & Medicaid Services (CMS), and the Institute for Healthcare Improvement that can be provided to participants at no charge.

CHA recommends that providers also be given the support and training necessary to test and implement quality improvement interventions related to the elimination of healthcare disparities. The American Hospital Association has [aggregated material](#) and published numerous resources that could be helpful to providers as they implement the program.

We would encourage the Practice Transformation Task Force to coordinate its efforts with the Department of Social Services with regard to care management. Recently, CHA submitted comments to DSS in reference to MQISSP. In these comments, CHA described how DSS seems to be intending to operate for the same populations at the same time two completely different approaches to medical management, which are not complementary. Hospital-sponsored networks would prefer that the medical management function be embedded within the advanced network and funded. However, if DSS intends to maintain its federated approach and/or will not fund local medical management, then DSS should clarify that the medical management service will be made available to the local entities from the statewide organizations and that DSS will amend its contracts with those organizations to require support to the local networks.

CHA appreciates the opportunity to offer comments and participate in reference to the CCIP Draft Report.

Sincerely,

Karen M. Buckley
Vice President, Advocacy

KMB:ljs
By E-mail