Healthcare Innovation Steering Committee

Practice Transformation Taskforce Update

August 13, 2015

Topics for Today's PTTF Update to the HISC

1. **Provide status update** on Community and Clinical Integration Program work since the last HISC update

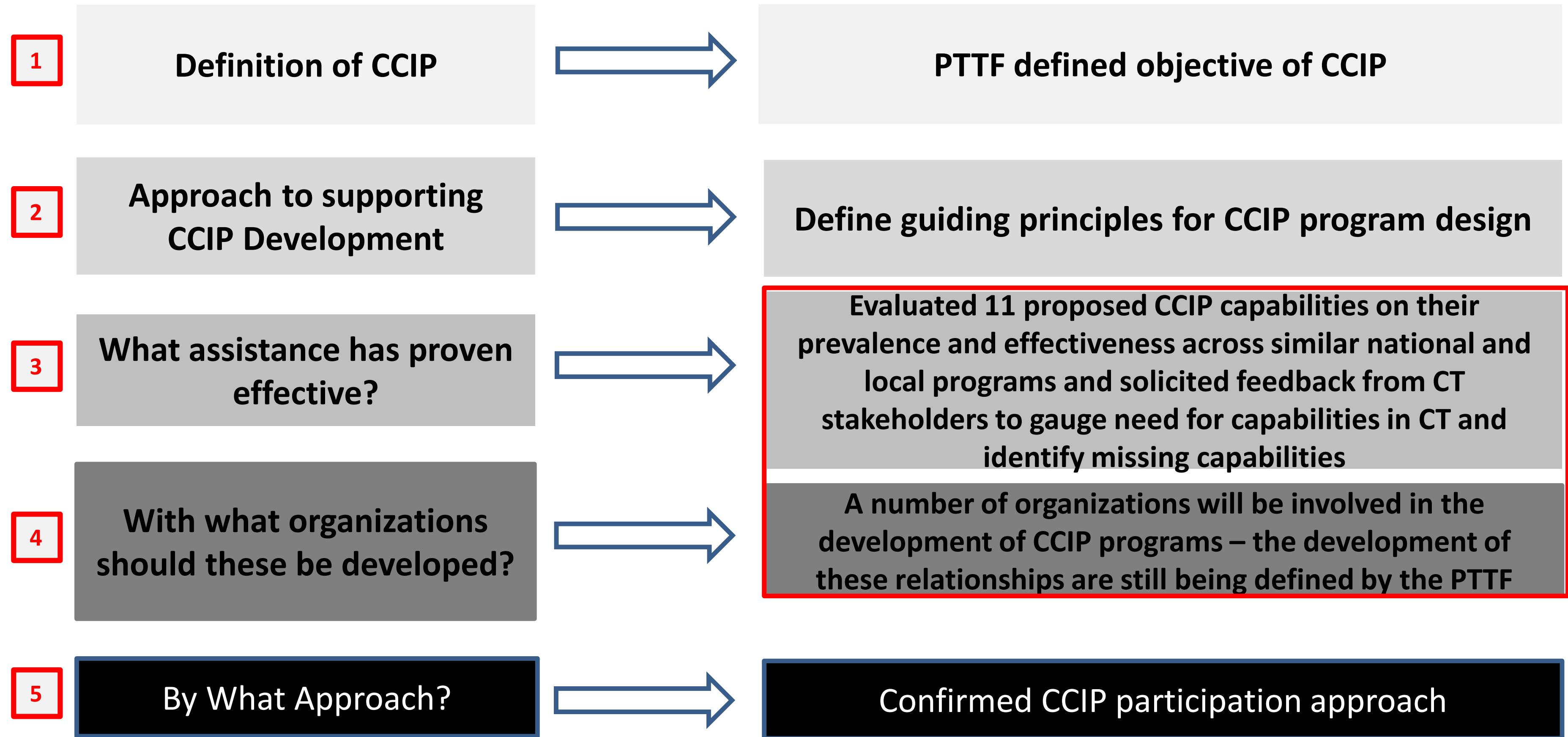
2. **Provide an overview** of progress to date and planned next steps

3. **Answer questions** that HISC members may have about the process and/or direction of the CCIP work

4. **Obtain input** from the HISC through a dialogue with the members

CCIP Progress Since Last HISC Update

Since the last CCIP update to the HISC, the PTTF has made significant progress across all design steps and is currently working on more detailed design elements.

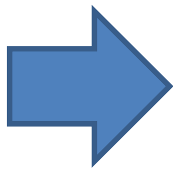


PTTF's Charge in the Context of SIM

1

SIM Vision

Healthcare system of today



More whole-person-centered, higher-quality, more affordable, more equitable healthcare

Health Care Delivery Transformation

SIM Initiatives

1 **Establish Advanced Medical Home Standards**

2 **Establish Community and Clinical Integration Program Standards**

PTTF Function/ Phase of Work

I Issue recommendations for required Advanced Medical Home standards to support whole-person centeredness at the **practice level**

II Issue recommendations on program design and standards for the **network** to guide the development infrastructure and processes intended to address patients who need services that are not typically provided within the primary care setting[1]

Focus through the end of 2014

Current Focus

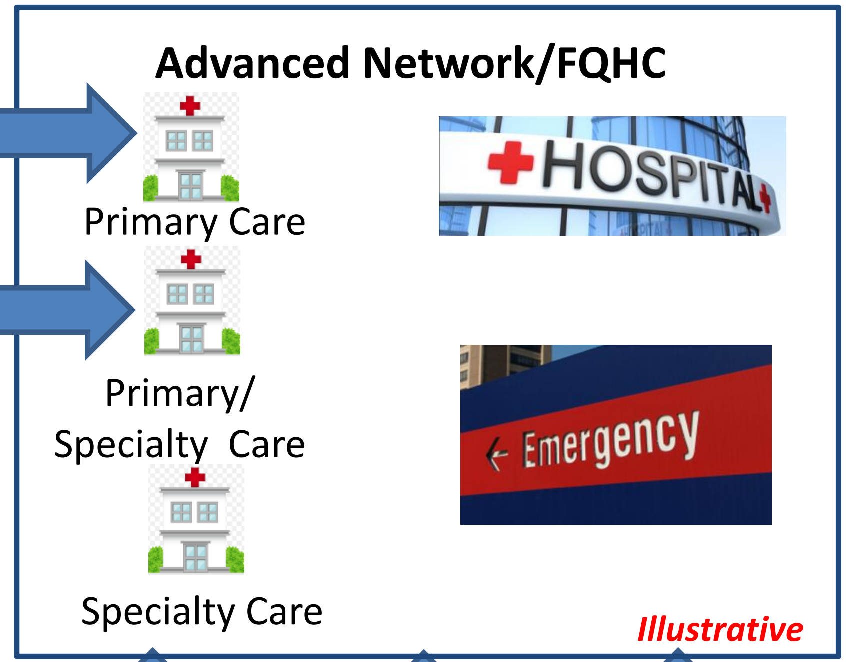
Notes:[1] This could include specialists that are outside the network (e.g.; behavioral health providers), clinically related support services (e.g.; pharmacists or dieticians), social support services (e.g.; housing or vocational assistance)

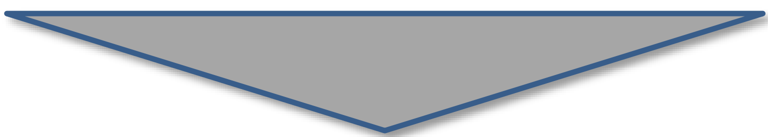
CCIP's Charge in the Context of SIM

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.

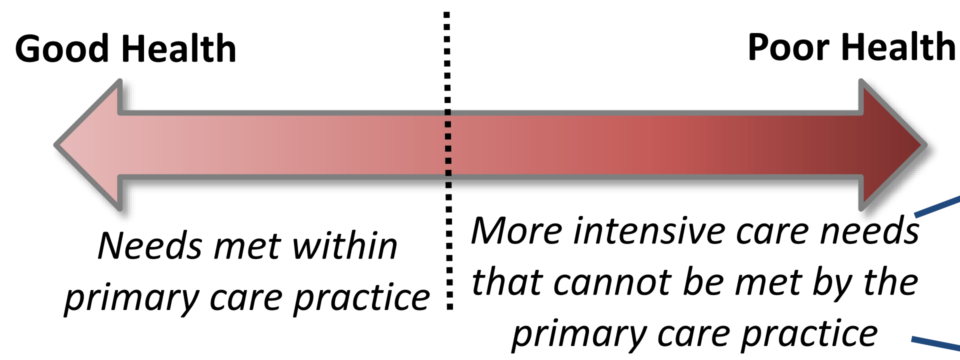
<u>AMH Standards promote</u>:

- 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)

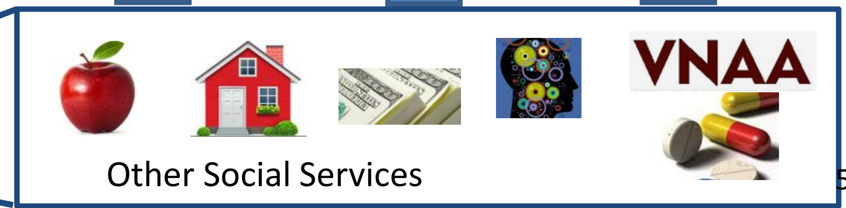




This will place patients on a continuum of care based on their health status



CCIP will create standards to integrate needed services into the network



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)

CCIP Approach

2

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

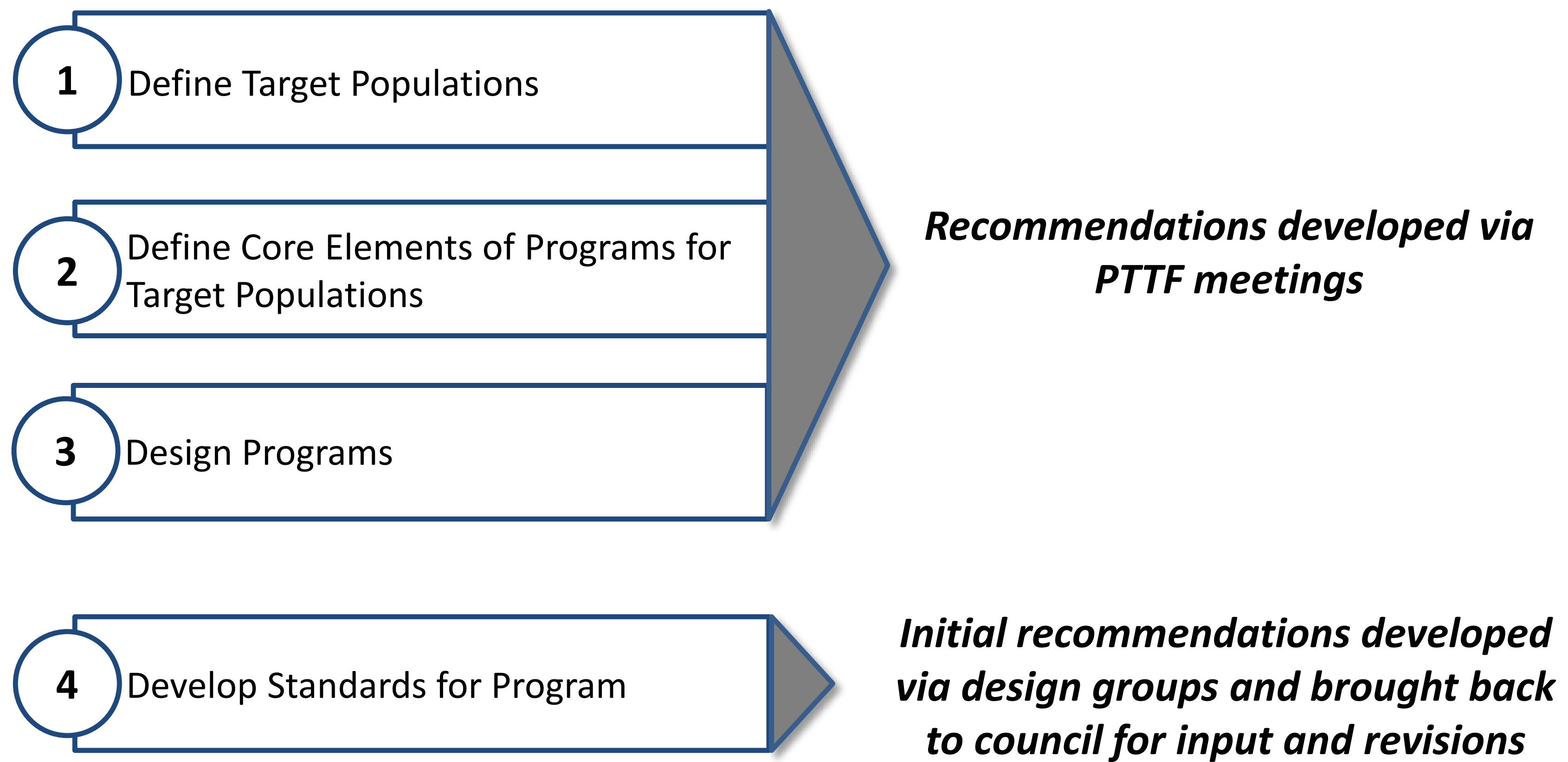
CCIP Objective:
Improve overall access to high quality clinical care for complex patients (either due to clinical reasons, social reasons or both), patients experiencing a gap in their care, and improve overall care experience for the general patient population through improving clinical and community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

CCIP Guiding Principles

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 PTTF 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

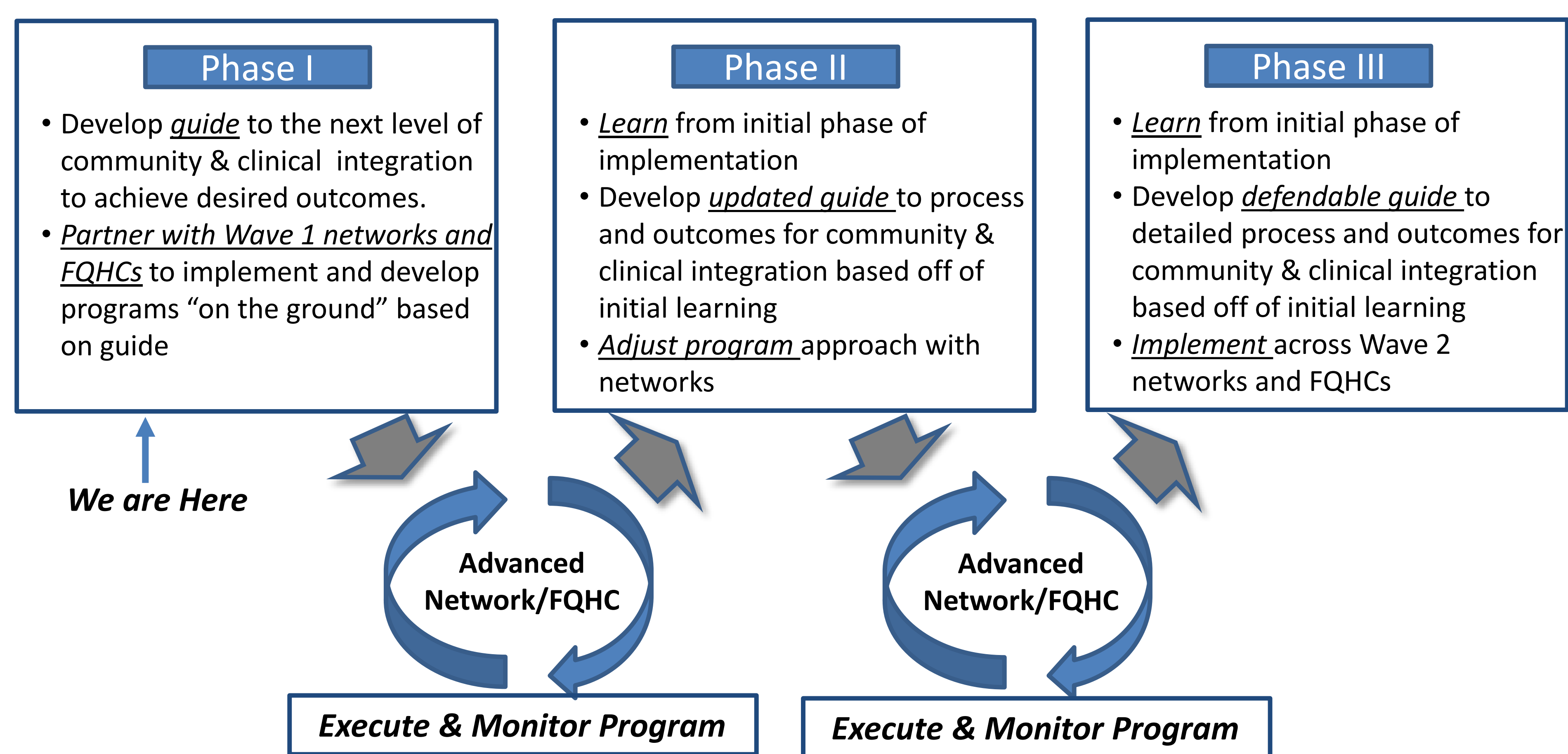
Will Fulfill Guiding Principle 2

Conversations started with HIT to support CCIP needs

CCIP Design Considerations

3

The PTTF 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 PTTF has sought to allow innovation around specific design details while providing standardization on implementation guidelines at a high level across networks.



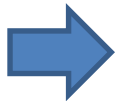
1 Define Target Populations

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:

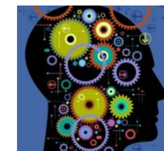


- Reduce readmissions and ASC admissions, ED use

Complex Patients (clinically and socially)

- Reduce health equity gaps

Populations Experiencing Equity Gaps



- PCMH CAHPS BH access
- BH screening/ depression remission

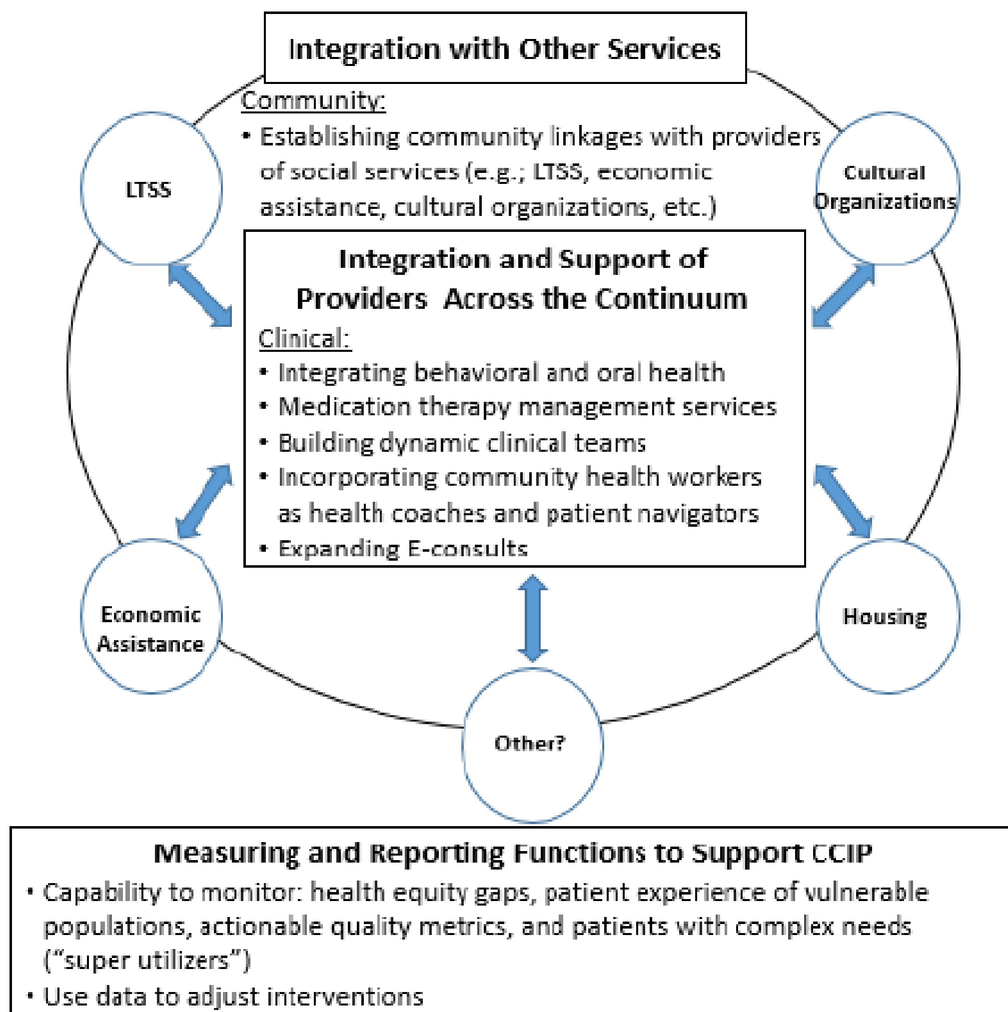
Behavioral Health

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

2 Define Core Elements of CCIP Programs

3

In considering which elements should be core to the CCIP program design, the PTTF 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)**

2 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 PTTF agreed to define these capabilities as core to the CCIP programs and the remaining and some additional capabilities as elective.

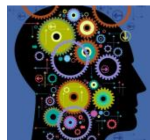
Core

Complex Patients (clinically and socially)

Multi-Disciplinary Team + *CHW* + *Community and Clinical Linkages*

Populations Experiencing Equity Gaps

CHW + *Community and Clinical Linkages*



Behavioral Health

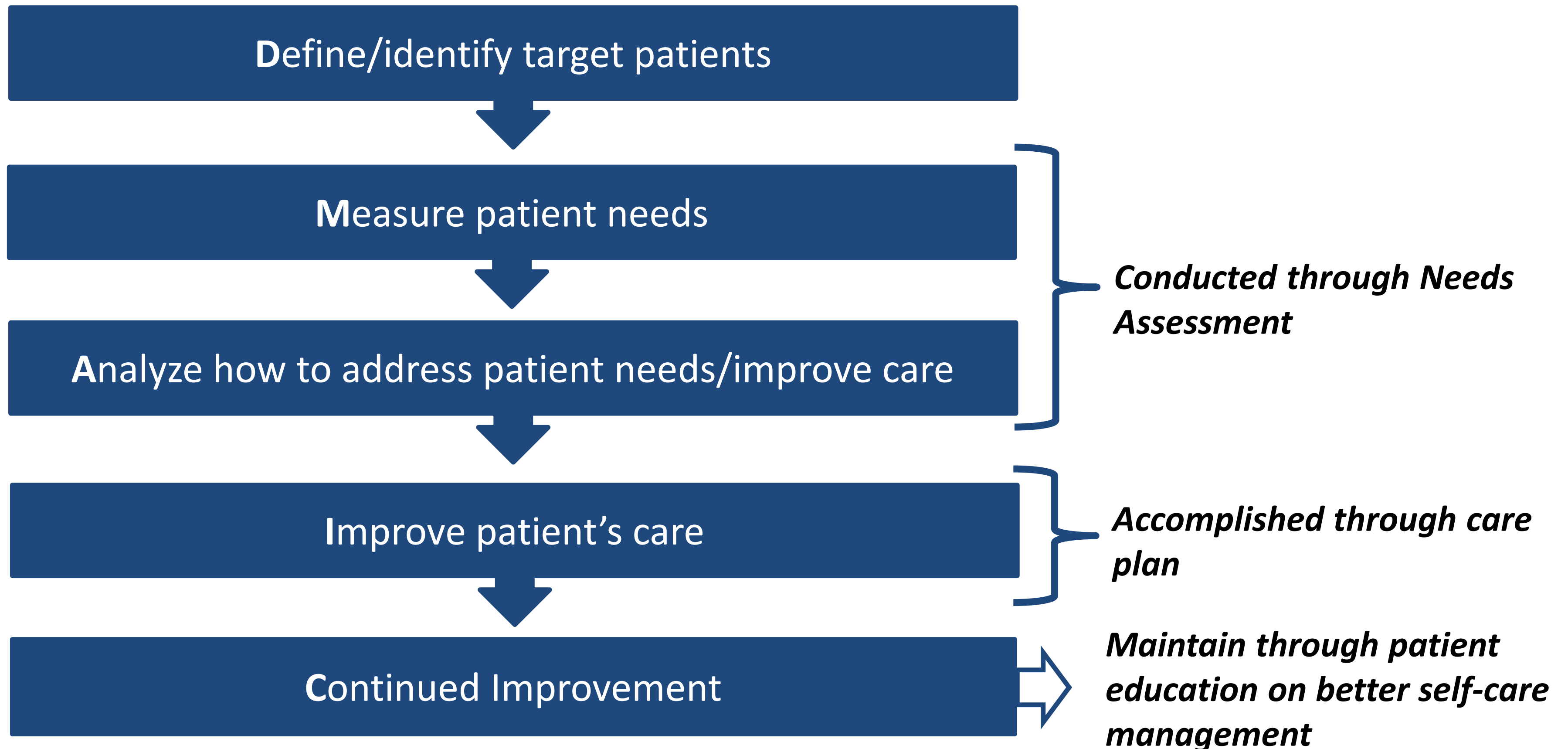
Behavioral Health Integration (screening, integrated BH care or referral to BH provider, confirm linkage to provider, follow-up)

Elective

Care Experience *Medication Therapy Management* *E-Consult* *Oral Health* *Care Transitions*

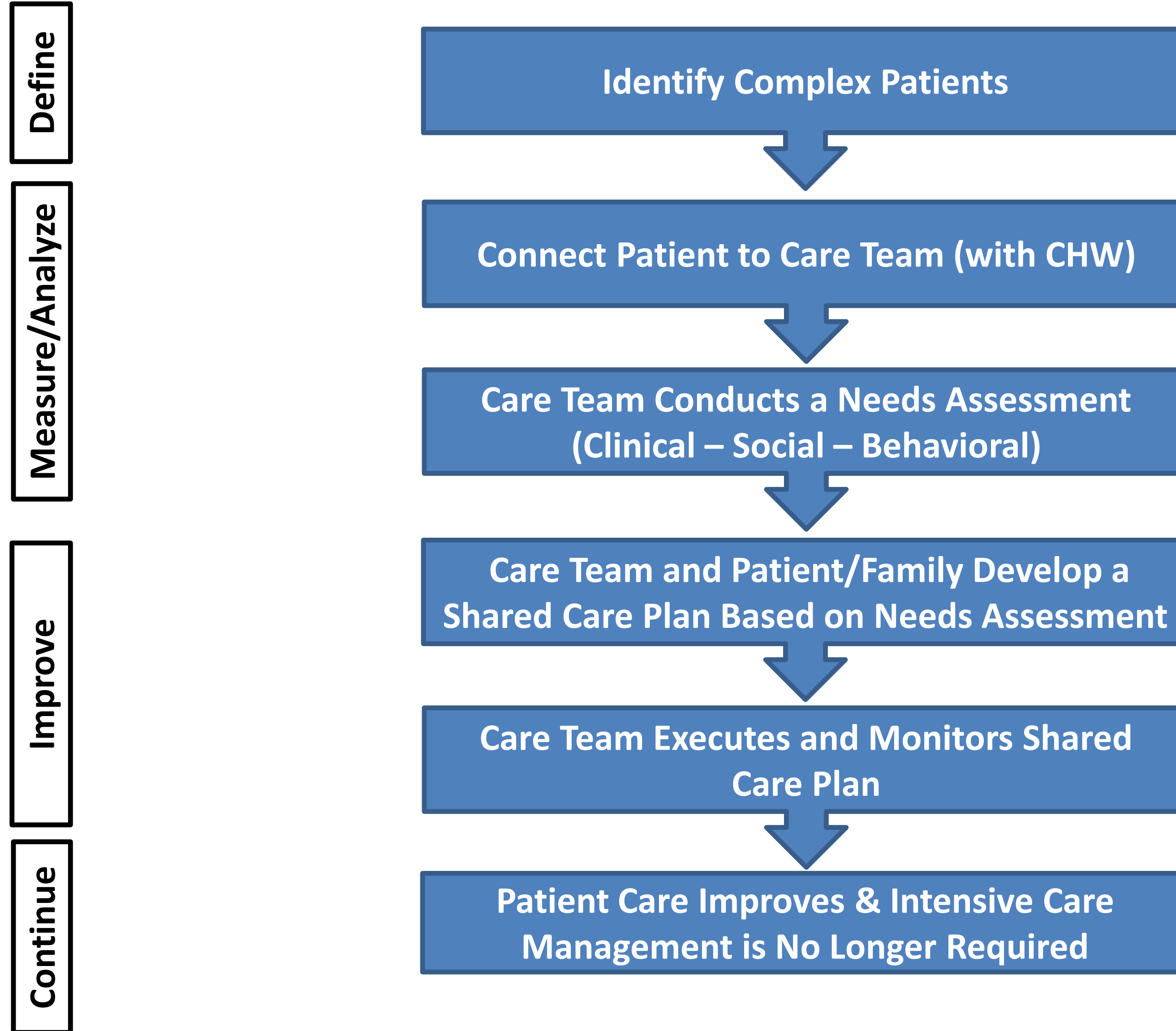
3 Design Programs

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.



3 Design Programs

Complex Patients



3 Design Programs

Draft 3

1. Identify Patients
2. Connect Patient to Care Team/CHW
3. Care Team conducts needs assessment
4. Care Team develops shared care plan with patient
5. Care Team executes and monitors shared care plan
6. Patient improves and no longer needs additional care management

Discussion Highlights

- PTTF agreed that the most important part of complex patient identification is to take into consideration utilization, health status, and social determinants of health data
- Regarding equity gaps, there is continued consideration for how prescriptive recommendations should be to define equity gaps – limit sub-populations and health status categories?
- Also discussing whether or not to broaden equity gap definition to look at differences in care provision (i.e.; evidence based guidelines vs. health status)
- Agreed to engage HIT to understand technology needs for desired analytics and survey networks to assess prevalence of needed technologies

Recommendation	Status
1.01 Patient Identification: Complex– At a minimum providers should deploy some type of basic analytic capabilities to risk stratify patients considering a combination of utilization data (claims) and clinical, behavioral, and social determinants of health data (EMR based). Networks should strive to use more complex analytics involving predictive modeling if possible.	Consensus - Pending questions on HIT

Design Programs

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Discussion Highlights

- With the exception of the community health worker the PTTF felt that recommendations should be made around specific functions that need to be fulfilled, but the networks should be free to choose who fulfills those functions (e.g.; RN vs LPN vs. APRN)
- The PTTF expressed interest in further exploring whether or not there are team based training protocols that could be recommended to networks

Recommendation	Status
1.03 Multidisciplinary Care Team Structure– It is recommended that the teams include the following functions: (1) a case management function, (2) a clinically focused care coordination function/patient navigation function, (3) patient liaison dedicated to patient education and management of social services that should be fulfilled by a CHW; and (4) a manager to oversee the coordination of functions and the complexity of delivering care across multiple settings. The MDT should also build out non-core team member functions who will provide on-going support in key areas (e.g. dieticians and pharmacists) as needed	Consensus
1.04 Multidisciplinary Team Behavioral Health – All teams should have open access to or have a team member who is a behavioral health professional capable of comprehensive behavioral health assessments	Consensus

Design Programs

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Discussion Highlights

- With the exception of the community health worker the PTTF felt that recommendations should be made around specific functions that need to be fulfilled, but the networks should be free to choose who fulfills that role (i.e.; RN vs LPN vs. APRN)
- The PTTF expressed interest in further exploring whether or not there are team based training protocols that could be recommended to networks

Recommendation	Status
1.05 Multidisciplinary Team Credentials - It is recommended that: (1) the behavioral health professional assigned to the core team be a clinician with at least a master's level license and (2) that Community Health Workers should receive certification required by the AN/FQHC and/or the contracted organization as well as any disease state specified training required to address the targeted equity gap. For all other functions there will be no mandatory minimum licensing recommendations.	Consensus
1.06 Multidisciplinary Team Case Load - There are different approaches to ensuring appropriate case-load (patients to team ratio) of the MDTs to ensure effectiveness of the Multidisciplinary Care Team. It is recommended that optimal ratios be developed by the local teams based off of the network needs.	Consensus
1.07 Multidisciplinary Team Training – It is recommended that all members of the care team receive team-based training including communications training in a team setting and methods to encourage person-centered orientation of care as well as a basic level of behavioral health training. Exact training protocols are not mandatory, but documentation of what training was conducted and that all multidisciplinary team members participated will be required.	Consensus With further research

Design Programs

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Discussion Highlights

- PTTF acknowledges that practices and networks differ in size and resources and will likely want to be able to make their own decisions about how to re-adjust or change their operations to meet the CCIP recommendation around the use of multidisciplinary teams
- Some PTTF members felt strongly that CHWs should not be employed by networks given that the intent of their role is to support the patient in the community and address their social needs outside the clinical setting
- PTTF ultimately agreed that as long as there is a recommendation that provides specific guidelines around the expectations/role of a CHW as part of the care team that the networks can be given the option to either employ or contract CHWs

Recommendation	Status
1.07 Multidisciplinary Care Team & CHW Relationship with Network–It is recommended that local practices adapt their own strategy to deploy the multidisciplinary team resources, including the decision whether to directly employ care team members within their current practices, at the network level, or to partner with an out of network organization as long as all functions are fulfilled with appropriate care team members and patient needs are being met.	Consensus
1.08 CHW Criteria: under development	na

Design Programs

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Discussion Highlights

- The PTTF is in the midst of the conversation regarding recommendations on the needs assessment and the care plan
- Initial thoughts on the needs assessment:
  - PTTF should provide a comprehensive understanding of the root cause of the patient's condition not just the immediate circumstances
  - Suggested guidance on the types of issues it should cover – patient history to determine how the team can best support patient goals, relevant clinical issues, social, and behavioral
  - Important to ask patient what they feel they are most challenged by
  - Discussed idea of an eco-map to assess patient history, but there was concern about assessment becoming too burdensome on patient and provider
- Initial thoughts on the shared care plan:
  - Should be patient centered and the patient should be actively involved in developing the plan
  - Should reflect the needs assessment
  - Should set treatment goals to be met within a specific timeframe

3 Design Programs

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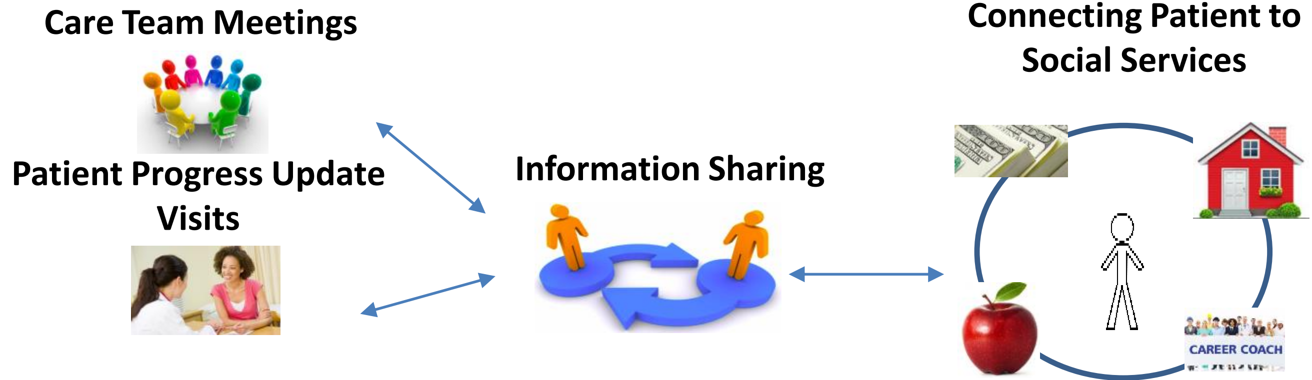
The remaining two steps are on the agenda to be discussed by the full PTTF at the next meeting.

Key Components of This Conversation Will Include:



Considerations	Discussions to Date
1. Protocols and processes for team communication (frequency, format, etc.)	• NA - Next PTTF Meeting
2. Protocols and processes for communicating on patient progress between meetings	• NA - Next PTTF Meeting
3. Technology solution to seamlessly share care plan and communicate with all team members, including community support services if necessary	• Started conversation with HIT (Present at 8/21 HIT meeting) • Design Group 3 to discuss on 8/20 • Assess current network capabilities
4. Relationship development with community orgs/social services (i.e.; governance and agreement type)	• Design Group 2 discussed 8/6 • In favor of shared governance
5. Relationship development with out of network clinically based relationships (i.e.; governance and agreement type)	• Began conversation with Design Group 2 and SMEs for BH integration

CCIP Timeline

PTTF-CCIP Timeline

	July	Aug	Sept	Oct
PTTF Meetings	28	TBD	1 TBD	8
CCIP Design Sessions	16	6 (DG 2) 19 (DG3)		
Key Activities				

PTTF articulation of standards for CCIP

Design groups support development of standards

Communication with MAPOC CMC and other key stakeholders[1]

Research, evidence review

Draft & edit report

Public input

Report revisions based on HISC feedback, additional coordination with MAPOC CMC as needed

1. Key stakeholders include:
   - Primary Care Coalition of Connecticut
   - Community Health Worker Association/Community Health Worker Focus Group (TBD)
   - Accountable Care Networks – test overall CCIP and assess technology needs in relation to CCIP
   - Community Organizations/Social Service Organizations (to be identified)

Questions?