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

October 5, 2015

SECOND DRAFT

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Overview

Connecticut's State Healthcare Innovation Plan (SHIP) articulates a vision to transform healthcare. Connecticut seeks to establish a whole-person-centered healthcare system that: (1) empowers individuals to actively participate in their healthcare; (2) improves care experience by ensuring superior access to safe, high-quality care; (3) eliminates health inequities; (4) improves population health; and (5) improves affordability by reducing unnecessary costs. In 2014 Connecticut received a $45 million grant from the Centers of Medicare & Medicaid Innovation (CMMI) to implement its plan for achieving this vision. The State Innovation Model (SIM) grant is the organizing vehicle through which programs in pursuit of this vision are developed, coordinated, and implemented.

SIM Transformation Initiatives

Connecticut's SIM initiative emphasizes the importance of investing in care delivery transformation that improves care coordination, builds community linkages, encourages whole-person centered care, and reduces health disparities. In order to understand our transformation strategy, it is important to understand how Connecticut's providers are organizing to provide healthcare today.

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

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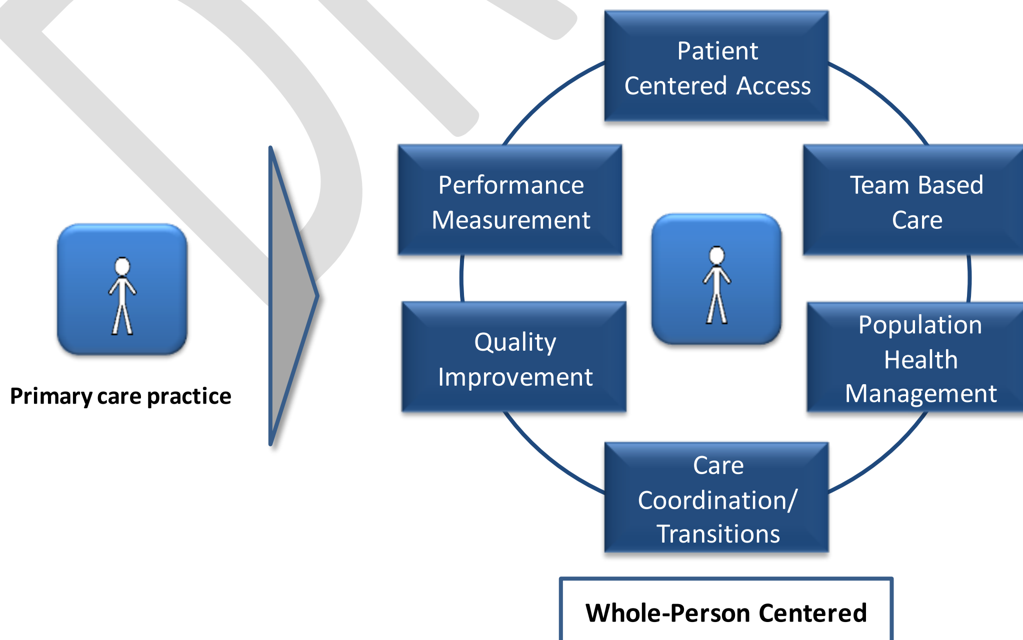
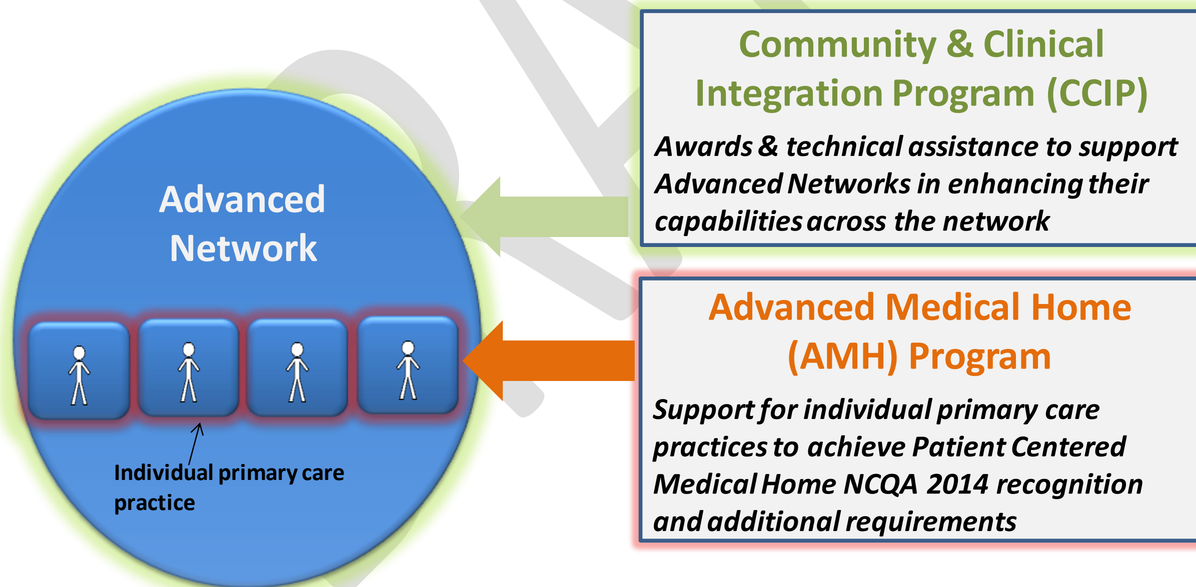
Advanced Medical Home Program

Webinars, peer learning & on-site support for individual primary care practices to achieve Patient Centered Medical Home NCQA 2014 accreditation as well as additional required criteria.



Most primary care practices are also part of a larger network of providers, which we call Advanced Networks. These Advanced Networks have organized to take responsibility for providing better quality care and lowering the cost of care by entering into value-based payment arrangements with Medicare and commercial health plans. Advanced Networks are also changing the way they do business. They are investing in new technologies, new staff (e.g., care coordinators), and they are changing their care processes. One of the biggest challenges that these Advanced Networks face is integrating their work effectively within the organization and coordinating effectively with key healthcare providers and community supports outside of the organization. Federally Qualified Health Centers (FQHCs) are also major centers for primary care and other services that are working to accomplish similar objectives.[1]

As part of our efforts to promote care delivery reform at the level of the Advanced Network and FQHC, SIM will fund the launch of the **Clinical and Community Integration Program (CCIP)**. CCIP is intended to support the advancement of Advanced Networks and FQHCs over the three year grant period (2016-2019). The SIM funded AMH program and CCIP are complementary initiatives designed to help these organizations realize their goals for better patient care at a lower cost. Whereas the AMH program focuses on individual practices, the CCIP program engages the overall organization in the process of developing new capabilities. Working directly with the organization and its leadership is the best way to introduce changes that require investments in the infrastructure (e.g., EHR) or changes to care processes that are standardized across the network of affiliated practices.

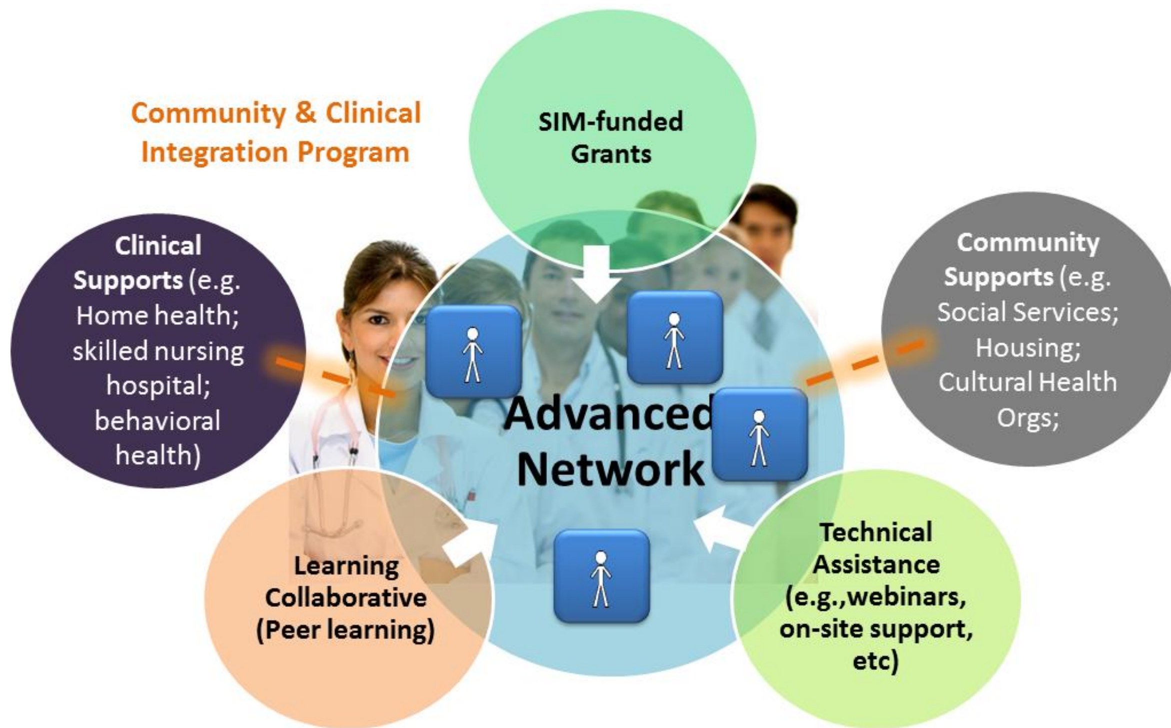


Community and Clinical Integration Program (CCIP)

One of CCIP's primary aims is to integrate more effectively **non-clinical community services** into routine clinical care. The need within Connecticut – and nationwide – for better integration of community and

[1] The Community Health Center Association of Connecticut, which represents FQHCs, was recently awarded a CMMI Practice Transformation Network grant. The state is reviewing whether this will affect their ability to qualify for CCIP funded assistance.

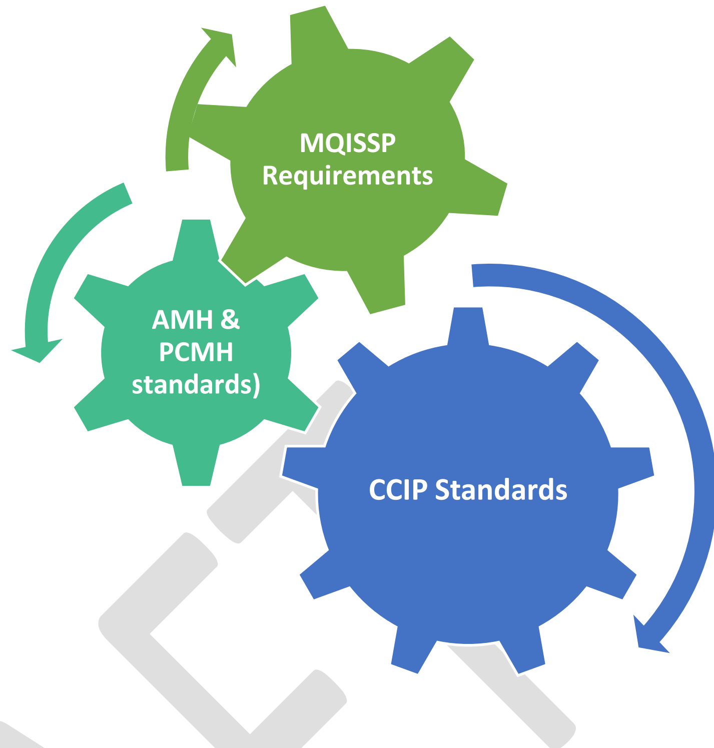
clinical services is well recognized; research has shown that 60% of a patient's overall health status is influenced by social circumstances, behavioral choices, and environmental conditions, most of which lie outside the reach of our healthcare providers. This means that achieving Connecticut's healthcare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



Which Providers Will Participate in CCIP?

Advanced Networks and Federally Qualified Health Centers (FQHCs) selected to participate in the Medicaid Quality Improvement and Shared Savings Program (MQISSP) will be required to participate in CCIP. Pairing CCIP with MQISSP aligns resources to support a shift in favor of efficiency, prevention, and continuous quality improvement. This aligns with the interests of providers that are expanding their participation in value-based payment models. These providers have strong incentives to perform well on quality measures and improve the overall efficiency and effectiveness of patient care processes.

Under CCIP, participating entities will receive technical assistance in developing new capabilities for improving care, especially for at-risk populations. They will be required to better engage patients as partners in their own healthcare and to help build coordinated systems that support patients' clinical and non-clinical needs. *It is especially important to note that the CCIP programs will focus on improving healthcare outcomes for all patients regardless of their insurance carrier (i.e., payer)*.



The SIM Program Management Office will contract with a transformation support vendor to help Advanced Networks and FQHCs meet the CCIP standards. Only Advanced Networks and FQHCs that are participating in MQISSP will be eligible for this transformation support.

CCIP aims to leverage and align with current and planned care coordination activities, including the AMH program, and the care coordination activities required under MQISSP. [2]

Program Design Process

A Practice Transformation Task Force (PTTF) was established in June 2014 as part of the State Innovation Model Initiative. The PTTF was 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. These eleven capabilities included the following:

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

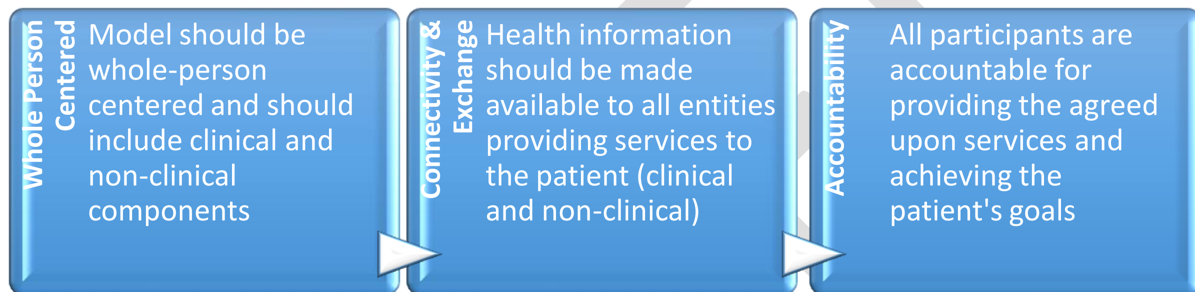
[2] The SIM program management office and DSS are examining how MQISSP requirements and CCIP standards can be coordinated. This will be discussed in a subsequent draft.

10) Identifying patients with high needs for community care team interventions
11) Producing actionable quality improvement reports

Evaluation of these eleven capabilities included literature reviews and technical assistance from the Center for Medicare & Medicaid Services (CMS) and CMMI. It also included input from subject matter experts and from Connecticut stakeholders with experience in these areas. All eleven capabilities were confirmed as important to include in the CCIP standards. However, the PTTF emphasized that the development of these 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 PTTF analyzed the effective deployment of models in other parts of the country. Through this process the PTTF developed **three guiding principles** for the design of the model:



Program Recommendations

CCIP is comprised of core and elective program standards. CCIP will require participating entities to meet the **core standards** (see Appendix A), which include the following:

- Comprehensive Care Management
- Health Equity Improvement
- Behavioral health

These core standards are designed to enhance competencies related to care management of individuals with complex needs[3] with a focus on person-centered assessment; care plans that emphasize individual values, preferences and goals; the enhancement of the primary care teams with additional clinical and community participants; and linkages with community based services and supports. The standards also introduce processes to support continuous quality improvement aimed at reducing health equity gaps and a related intervention targeting hypertension, asthma, or diabetes. Community health workers play an important role in these standards, recognizing that community health workers can serve as a trusted partner and bridge to community services and supports. The third of these standards focuses on individuals with unidentified behavioral health needs. The standards address screening, primary care based treatment, referral, and coordination with behavioral health care in the community.

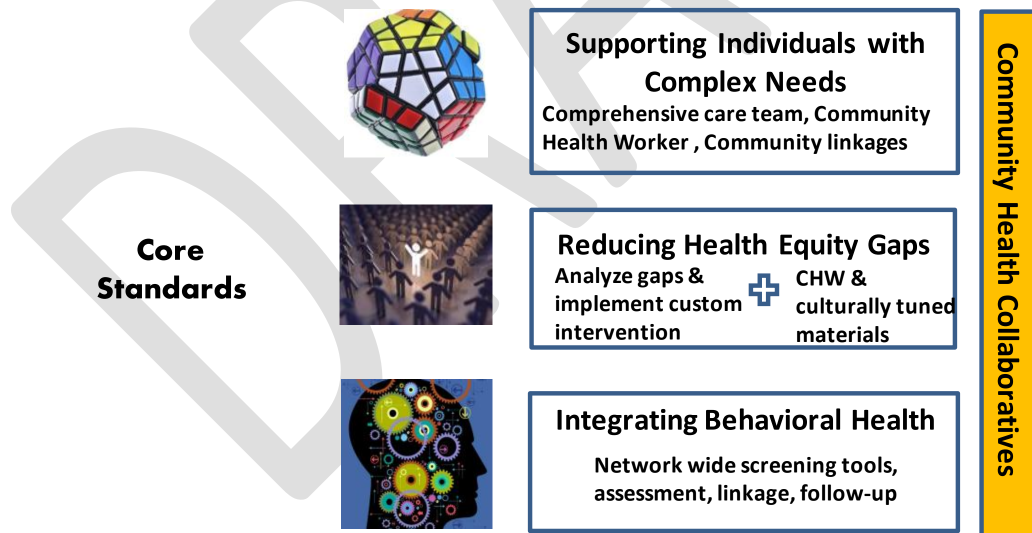
[3] Patients with complex needs are defined as: Individuals who have or are at risk for multiple complex health conditions, multiple detrimental social determinants of health, or a combination of both that contribute to preventable service utilization and poorer overall healthcare management that negatively impacts the individual's overall health status.

CCIP will also encourage participating entities to meet **elective standards** (see Appendix B), which include:

- Electronic Consults (“e-consults”)
- Comprehensive Medication Management ("CMM”)
- Oral Health

The elective standards represent best practices in areas that complement the core standards. However, the elective standards are not limited to patients that fall within the populations that are the focus of the core standards. The elective standards provide an evidence-based framework for providers who choose to pursue these capabilities. The e-consults standards address the lack of access to specialty providers by establishing protocols for primary care providers to consult with specialists. This model has been shown to decrease costs, increase access, and enhance primary care provider capabilities. The CMM standards provide a framework for providers to engage patients with complex medication regimens to increase adherence and reduce complications. The oral health standards are designed to increase oral health access and capabilities within the primary care setting.

To accomplish the seamless integration of community based service and support providers, community linkages will be established through CCIP’s requirement to convene local **Community Health Collaboratives**. These Collaboratives will be tasked with establishing community-wide processes for the seamless coordination, communication, and integration of clinical services with community services and supports to address the range of patient needs (see Appendix C). Protocols that support safe and effective care transitions will be one important area of focus.



Elective Standards

Comprehensive Medication Management
E-Consults
Oral health

SIM funded health information technology is expected to play a significant role in supporting these capabilities. The SIM program management office and DSS will continue to work with stakeholders to define CCIP related health information technology needs and to determine how these needs can be supported through technical assistance or SIM-funded technologies.

Taken together, the program standards represent a model that achieves the guiding principles and begins the process of integrating clinical and non-clinical services into a system of person-centered care. In recommending these standards, the PTTF 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 include both required actions to be taken as well as suggested actions or references to successful models in other markets across the country. It is the hope of the PTTF that this model will provide Advanced Networks and FQHCs with the tools to provide comprehensive, person-centered care to their entire patient population.

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1. Connecticut State Innovation Model Background

The State Innovation Model (SIM) program, administered by the Center for Medicaid and Medicare Innovation (CMMI), awarded federal grants to states committed to developing and implementing multi-payer healthcare payment and service delivery model reforms that will improve healthcare 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: (1) empowers individuals to actively participate in their healthcare; (2) improves care experience by ensuring superior access to safe, high-quality care; (3) eliminates health inequities; (4) improves population health; and (5) improves affordability by reducing unnecessary costs.

SIM is intended to serve as an organizing and funding vehicle to support states in the pursuit of their vision. 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, promote value based payment and insurance reform, encourage quality measure alignment, update health information technology, implement a Medicaid Quality Improvement and Shared Savings Program, and transform primary care.

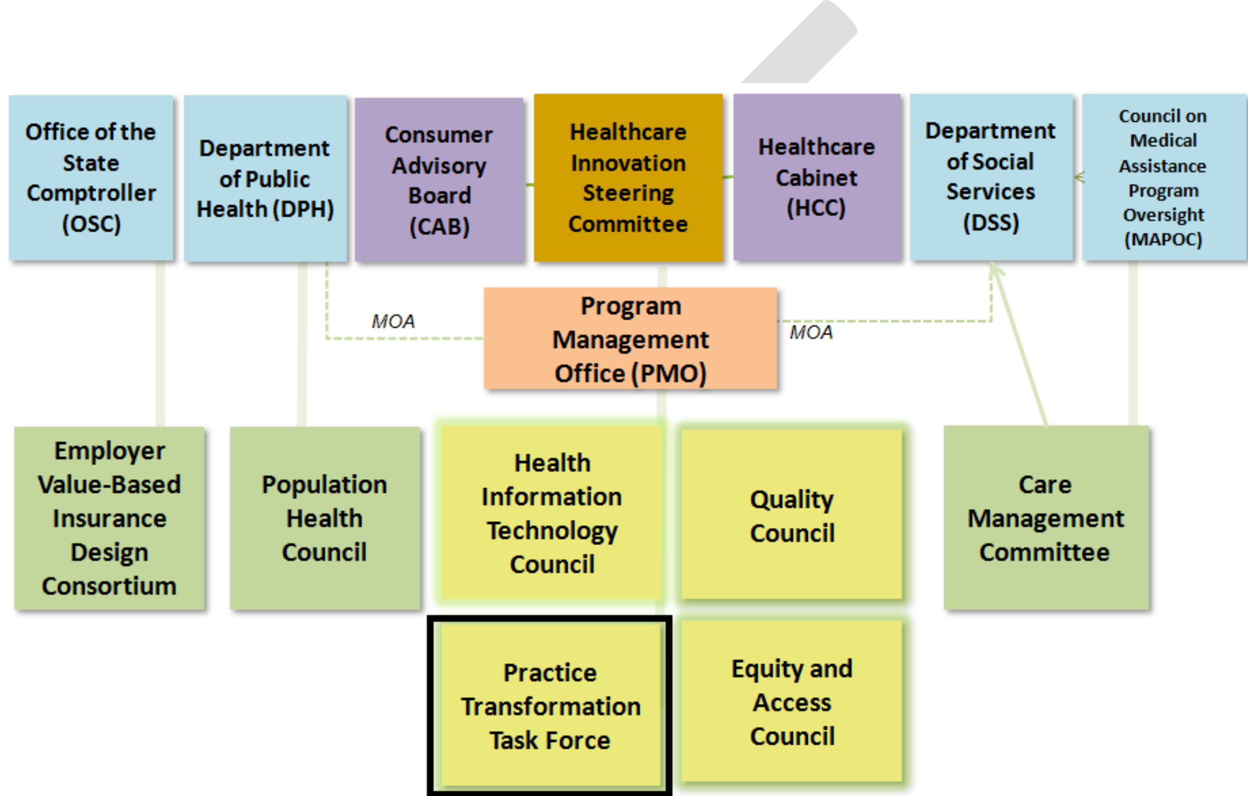
Definitions:

Person-Centered: Person-centered care engages patients as partners in their healthcare and focuses on the individual's choices, strengths, values, beliefs, preferences, and needs to ensure that these factors guide all clinical decisions as well as non-clinical decisions that support independence, self-determination, recovery, and wellness (quality of life). The individual engages in a process of shared-decision making to make informed decisions about their care plan and treatment. The individual 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.

Value Based Payment: 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 of visits and services. 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).

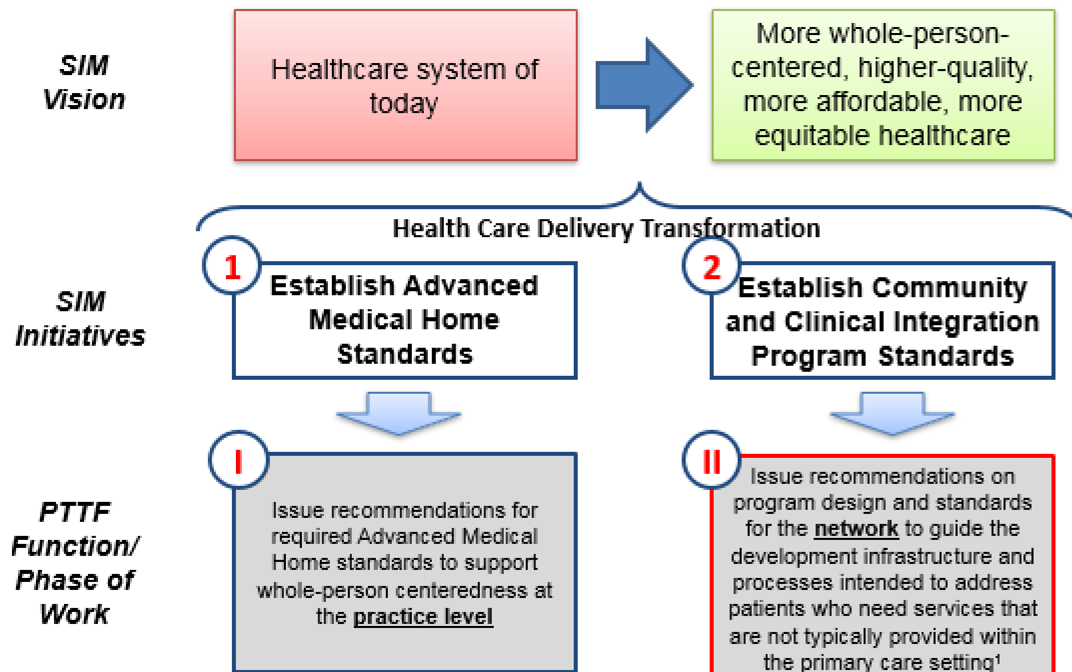
Shared Savings Program: A form of a value based payment that offers incentives to provider entities to reduce healthcare spending for a defined patient population by offering physicians a percentage of the net savings realized as a result of their efforts. Savings are typically calculated as the difference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

Oversight of Connecticut's SIM initiative is provided by the Healthcare Innovation Steering Committee, which is chaired by Lieutenant Governor Nancy Wyman. The design and implementation of the SIM component initiatives is informed by a number of advisory groups that are supported by the SIM Program Management Office (PMO) or by our partner state agencies. The work group responsible for generating the recommendations included in this report is the Practice Transformation Taskforce's (PTTF). In addition to the PTTF, there are work groups focusing on: Health Information Technology, Quality Measure Alignment, and Equity and Access. The work groups are supported by the SIM PMO. The Consumer Advisory Board is a key advisor to both the Healthcare Innovation Steering Committee and the SIM PMO, and is the lead entity providing recommendations on consumer engagement.



2. The Role of the Practice Transformation Taskforce

The PTTF is responsible for advising on the design of SIM funded program that enable care delivery reforms consistent with the SIM vision. To accomplish its work, the PTTF split the work into two phases. In the first phase of work the PTTF was charged with developing Connecticut Advanced Medical Home standards. In 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), and social support services (e.g., housing or vocational assistance)

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

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

Initial Design Process

The PTTF began its work with the following three objectives: (1) Gain a better understanding of the eleven capabilities set forth in the grant and their relative effectiveness; (2) Understand how local and national programs were addressing similar objectives; and (3) Evaluate how these capabilities could be most impactful for the residents of Connecticut.

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

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

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 Task Force:

- Reviewed literature on the effectiveness of these capabilities
- Solicited Center for Medicaid and Medicare Innovation (CMMI) technical assistance[4]
- Conducted interviews (see Appendix G 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 PTTF's evaluation of the individual capabilities concluded that **each capability is an important element in supporting the objectives of CCIP (see Table 1)**.

[4] 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.

Table 1

#	Capability	Effectiveness
1	Behavioral Health	• Reduction in overall medical care and cost through better behavioral health integration into primary care aimed at identifying needs earlier and addressing them appropriately (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	Comprehensive Medication Management	• Reduced medication and other health care utilization cost/claim and annual cost/patient; Improved patient satisfaction (Smith M, 2013)
4	Electronic 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
9	Identifying High Needs Patients	• 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 program results for patients with high needs 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)

* The term “dynamic clinical care team” was changed to **comprehensive care team** to more accurately describe the purpose of the team as reflected in the literature.

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While each of the eleven capabilities can contribute to better care, their effective deployment as an integrated program depends on how the capabilities relate to one another and which populations they are intended to support. The PTTF therefore focused on how to build a set of capabilities that encompass the eleven areas, combining several of them into a core standard set and others into an elective standard set. All of the core standards emphasize a person-centered approach and other features that should result in improvements in care experience.

Core Standards

Supporting Individuals with Complex Needs
Comprehensive care team, Community Health Worker , Community linkages

Reducing Health Equity Gaps

Integrating Behavioral Health
Network wide screening tool & assessment, , linkage, follow-up

Elective Standards

Comprehensive Medication Management
E-Consults
Oral health

Extended Design Process

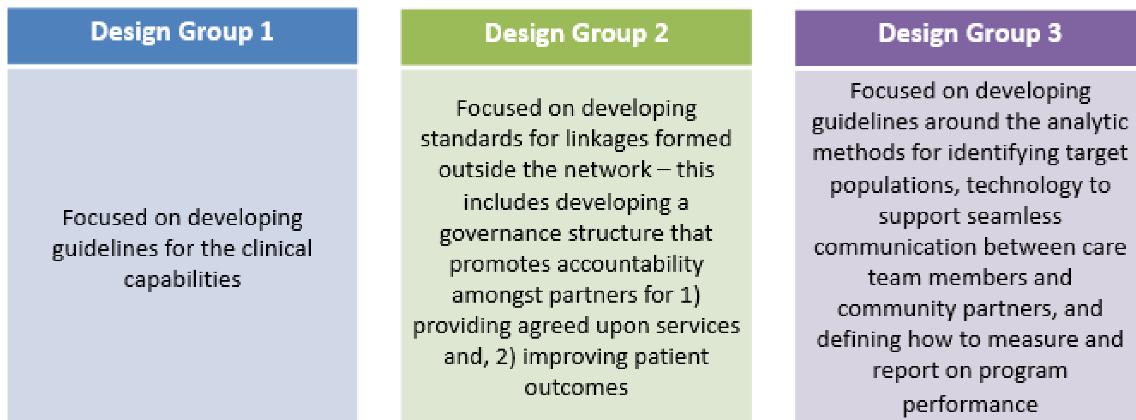
The PTTF organized the balance of the **design process** to accomplish the following:

1. Identify the **high-needs** sub-populations to be the focus of CCIP interventions;
2. Define which program capabilities would be core to addressing the needs of these focus populations and which would be elective;
3. Design programs with flexibility to customize to local needs; and
4. Promulgate evidence-based standards for networks to implement these programs.

Definition:

"High Needs" Patients: Individuals whose complex medical conditions are often compounded by physical, behavioral, environmental, oral health, or socioeconomic factors that are not well managed by the current healthcare system. As a result, these individuals have frequent ER visits and hospital admissions or re-admissions due to unresolved, often preventable complications that drive up healthcare costs and result in poor patient outcomes.

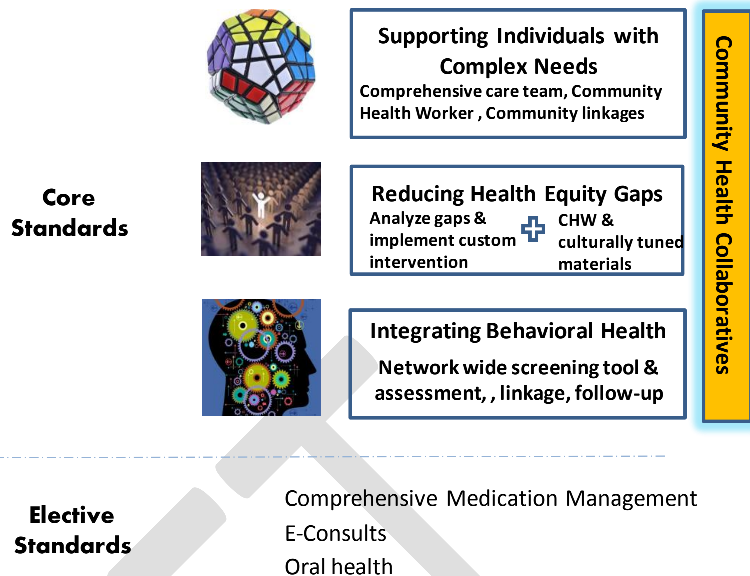
The PTTF first determined the focus populations and the associated core vs. elective capabilities. The taskforce then split into smaller **design groups** to aggregate the expertise of certain members around specific model components. The design groups addressed the detailed design elements of the capabilities to address the needs of each focus population (high level program design and standards) as follows:



The design groups reviewed program design options and standards in more detail. These groups then summarized their discussions and conveyed their points of view to the full PTTF for further analysis to finalize the recommendations for each focus population. PTTF members were assigned to different design groups based on their backgrounds, expertise, and interests and were asked to attend and participate in two design sessions throughout the process. Design group meetings were open to all PTTF members and the public.

As it developed its recommendations for comprehensive care management, the PTTF recognized the need for communities to develop standardized processes to link community and social service resources with traditional clinical providers in their respective service areas. The PTTF proposed the creation of **Community Health Collaboratives** comprised of local stakeholders that would be tasked with

developing protocols for better integration of shared resources into the provision of healthcare service (see Appendix C). The protocols would help standardize coordination and communication and enable more efficient care transitions. Advanced Networks and FQHCs would be required to participate in these local collaborative efforts and adopt processes for care management and care transitions that align with the community-wide protocols.



In the final phase of its development of the standards, the SIM PMO sought review and input from the Care Management Committee of the Council on Medical Assistance Program Oversight (MAPOC CMC), which provides oversight of Connecticut's Medicaid program.[5] The SIM PMO also posted the draft report and standards on its website and invited public comment.

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CCIP Implementation Approach

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

The transformation vendor is expected to: (1) assist the network in conducting a needs assessment to confirm that CCIP core areas of assistance align with network needs[6]; and (2) undertake a gap analysis to inform an implementation plan for CCIP technical assistance. The plan will include an assessment of which core standards are not being fulfilled and identifying what will be needed to implement them going forward. If networks are already fulfilling the needs of the focus populations and meeting minimum standards, then CCIP support will not be provided so as not to disrupt existing effective care coordination efforts.

Additionally, the transformation vendor will make an assessment about the feasibility of the network to fulfill the core intervention standards over the 15 month support period based on the current state of

[5] 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).

[6] 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.

the network capabilities. If it is determined by the vendor that it will not be possible to fulfill all core interventions over the 15 months, the vendor and the provider will prioritize which intervention standards will be implemented first, based on the needs of the network's population. The provider will be required to submit a plan for meeting the remaining standards on a timetable negotiated with the SIM PMO.

The transformation vendor will be expected to provide access to training and resources to support Advanced Networks and FQHCs in their quality improvements efforts.[7] Providers need to be familiar with the science of improvement, change management, and performance measurement. Interventions associated with CCIP may benefit from the use of a cycle of change methodology (e.g., Plan-Do-Study-Act) to assess the effectiveness of an intervention prior to implementing, or spreading, the change throughout the organization. Consideration will be given to allow providers time to test adequately interventions prior to network wide implementation. Providers will be encouraged to include at least one CHW is in the quality improvement team that conducts cycle of change testing for the interventions that propose CHW involvement, such as the elimination of healthcare disparities.

It is anticipated that the transformation vendor charged with providing technical assistance will also be responsible for initiating the Community Health Collaborative process by convening the participating networks and community stakeholders to develop the consensus protocols for coordination and a long-term sustainable plan for local oversight.

Many of the capabilities promoted in CCIP depend on health information technology. The SIM model test grant proposes funding a menu of technology tools that could serve as enablers to participating Advanced Networks and FQHCs. An example of this is the technology necessary to support the deployment of electronic admission, discharge, and transfer alerts. Other technologies will be required, funding for which will be the responsibility of the providers and which will likely require ongoing development and associated investments. The SIM PMO, DSS and the UConn HIT technology team will work with the HIT Council and PTTF to further define those program needs where SIM funded technology would be most appropriate. The PMO will also examine commitments to participate in such technology solutions that might be required as a condition of participation in CCIP.

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[7] Quality improvement resources are also available from the American Hospital Association, the Centers for Medicare & Medicaid Services (CMS), and the Institute for Healthcare Improvement at no charge.

4. CCIP Focus Population Definitions

Whole-person centeredness has been a foremost consideration in the design of CCIP. The PTTF considered state and national model programs that designed interventions around specific populations. The focus on designated populations promotes whole-person centeredness to the extent that it reflects the individual needs of the patients within that population.

While many sub-populations within Connecticut can be identified, the PTTF focused on populations that had a demonstrated need for improved care manifested by poor health outcomes, unnecessary and preventable health care utilization, or a combination of both (The Center for Health Care Strategies, Inc., 2014) (Center for Health Care Strategies, Inc., 2015).

The recommendations balance the need to standardize practice with the flexibility to tailor networks' approaches to meet the needs of their patients. Areas of standardization generally reflect evidence-based best practices. Although some CCIP program components identify pre-determined focus populations, the program also allows flexibility to more specifically define the focus population to meet the needs of patients attributed to their networks. The PTTF explored the objectives of CT SIM and the needs of the State more broadly to help identify the most appropriate focus populations for Advanced Networks and FQHCs.

To define the focus populations for CCIP the PTTF considered the following **criteria**:

#	Design Consideration Criteria	Why Is This Important?
1	Alignment with stated SIM goals	• Aligns CCIP with shared savings program rewards so that there is financial support for program investments
2	Alignment with needs of Connecticut	• Positions CCIP to advance Connecticut's population health goals while remaining payer agnostic
3	Standardization balanced with flexibility	• Ensures some level of consistency in how CCIP is implemented across networks • Promotes whole-person centeredness

Based on the above considerations, **three focus 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: (1) patients with complex needs, (2) patients experiencing equity gaps, and (3) patients with unidentified behavioral health needs. The definitions for these populations are as follows:

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

Patients Experiencing Equity Gaps: Individuals 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 focus on diabetes, hypertension, and asthma, as these conditions are among the State's priority areas in the

Department of Public Health's Chronic Disease Prevention and Health Promotion Plan[8] and are target areas for improvement in the SIM Provisional Quality Measure set. The identification of additional sub-populations defined by race, ethnicity, and sexual orientation/gender identity who are experiencing equity gaps will be encouraged.

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

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

Design Considerations	Focus Populations		
	Complex	**Equity Gaps**	**Behavioral Health**
Alignment with CT SIM and CCIP	• Reduce readmissions and ASC admissions • Reduce ED use	• Reduce health equity gaps	• PCMH CAHPS behavioral health access • Behavioral health screening/depression remission
Alignment with Connecticut Health Needs	• Absence of programs to address complex needs for broader patient population • Complement specialized care management interventions in Medicaid for individuals with highly specialized needs	• Known gaps in care in the state along racial and ethnic lines (Connecticut Healthcare Innovation Plan, 2013)	• 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 focused on individuals with severe and persistent mental illness
Flexibility	• 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	• 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	• 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 behavioral health needs viewed to be most prevalent amongst their patient population

[8] http://www.ct.gov/dph/cwp/view.asp?a=3137&Q=543772

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5. CCIP Detailed Intervention Design: Core and Elective Interventions

Core Interventions for High Needs Populations

Individuals with Complex Needs

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

Members of the comprehensive care team are responsible for doing a comprehensive "whole" person needs assessment and then using this assessment to ensure that the care plan includes all of the many elements of services and support that must be coordinated and aligned to achieve a favorable outcome. This assessment may include visiting the patient's home. Importantly, the comprehensive care team must be capable of establishing effective linkages with essential community supports such as social services. At some point, the patient's level of risk or complexity may improve such that the core primary care team can assume responsibility for long term follow-up. In other cases, the patient's level of complexity may be such that this comprehensive care team must continue, with changes in composition appropriate to the individual's evolving needs.

Care Model Research and Design for Individuals with Complex Needs

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

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

objective of a care management team is to focus on in-person care management and the integration of primary care and community resources.

Successful care management is accomplished when individuals are engaged in their care, feel supported by their providers, and have their full range of clinical and non-clinical needs addressed. The common tools used by these teams include needs assessments and care plans. The needs assessments are used to identify clinical, social, and behavioral health needs. A person-centered care plan supports the individual in achieving care goals by ensuring transparency, portability, and continuity of information about health conditions, personal preferences, and goals of care (Spencer A, 2015) (Samuelson, 2015) (Hawthorne, 2015) (Health, 2014). At a high level the following **program design** is commonly used:

1. Identify the focus population;
2. Connect the individual to a comprehensive care team[9] charged with providing intensive care management;
3. Conduct a person-centered (see Appendix E for a list of definitions) needs assessment that informs the development of a care plan, with a focus on the individual's non-clinical (i.e.; social and behavioral) needs;
4. Execute the care plan, ensure updates are communicated to the care team, connect the individual to needed clinical and non-clinical services, and support the individual to transition to routine primary care team follow-up and self-directed care management; and
5. Track the individual, periodically reassess, and reconnect with the individual if needed.

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

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

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

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

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Patients Experiencing Equity Gaps

It is well established 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).

The PTTF felt that it was important to establish Connecticut-specific standards for Advanced Networks and FQHCs to do continuous equity gap improvement. This 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 that are prevalent in their communities[10].

While the continuous equity gap improvement standards require a root cause analysis, the PTTF also recommended 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. This will allow networks flexibility in customizing interventions and focus populations consistent with their local communities.

The PTTF considered the integration of a community health worker into the primary care setting to provide more culturally and linguistically appropriate care in the development of its health equity gap intervention. Often gaps in care arise from language barriers, challenges with the cultural competency of providers, and cultural gaps in patient education, in particular for patients with chronic illnesses and for patients that require a change in lifestyle as part of their treatment (Perez-Escamilla R, 2014). Research has demonstrated the use of community health workers to address these gaps 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 focus population definitions (The Institute for Clinical and Economic Review, 2013).

In the studies demonstrating positive results, the CHWs are usually representative of the population they are supporting by either being from the community or by being ethnically/racially and culturally similar to the patients. The interventions carried out by the CHWs are intended to engage patients in

[10] For full standards please see: Health Equity: Continuous Quality Improvement Standards at the end of this section

self-care management by 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 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 engagement in addressing the specific equity gap. 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 patients with complex needs:

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 care management

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

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

The PTTF considered the best practices emerging from other CHW programs and research trials in addition to members' expertise and experiences as providers, payers, and consumers of healthcare in Connecticut (see Appendix D).

Patients with Unidentified Behavioral Health Needs

A wealth of research exists regarding the positive health outcomes and cost benefits that occur when behavioral health is better integrated with primary care. 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:

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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:
• 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	• 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	• 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	• 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	• 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	• 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 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 behavioral health conditions will likely benefit from a coordination model (Integrated Behavioral Health Project, 2013).

Given the focus on patients with previously unidentified behavioral health needs, the taskforce agreed that CCIP should create standards 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 PTTF 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?

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The PTTF considered the well-established best practices of behavioral health integration when addressing these core design questions (see Appendix D).

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Appendices

Appendix A: Community & Clinical Integration Program – Core Standards

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COMPREHENSIVE CARE MANAGEMENT

FOCUS POPULATION: INDIVIDUALS WITH COMPLEX NEEDS

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

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

Program Description and Objective:

Description: Complex care management is a person-centered process for providing care and support to individuals with complex needs. The care management is provided by a multi-disciplinary *comprehensive care team* comprised of members of the primary care team and additional members, the need for which is determined by means of a person centered needs assessment. The comprehensive care team will focus on further assessing 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.

The intervention standards for individuals with complex health needs are intended to complement existing medical home and care coordination programs in Connecticut. The standards will enable medical homes to identify more effectively individuals who would benefit from comprehensive care management, engage those individuals in self-care management, and coordinate services by means of comprehensive care team that includes community-based service and support providers. The additional components of the individual's care plan and the services provided will be communicated directly back to the primary care team and coordinated as the individual progresses through the program. The ability of participating providers to meet the standards through existing programs vs. the need to develop supplemental capabilities, will be determined by means of a readiness review or gap analysis conducted by the transformation vendor at the start of the program.

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

Person-Centered Definition:
Person-centered care engages patients as partners in their healthcare and focuses on the individual's choices, strengths, values, beliefs, preferences, and needs to ensure that these factors guide all clinical decisions as well as non-clinical decisions that support independence, self-determination, recovery, and wellness (quality of life). The individual engages in a process of shared-decision making to make informed decisions about their care plan and treatment. The individual 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.

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High-Level Program Design:

1. Identify individuals with complex needs
2. Establish a comprehensive care team
3. Connect individuals to the comprehensive care team
4. Conduct person-centered assessment
5. Develop a comprehensive care plan
6. Execute and monitor the comprehensive 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 the support of a comprehensive care team by using analytics to develop a risk stratification[11] methodology that takes into consideration utilization data (claims-based) and clinical, behavioral, and social determinant risks (EMR-based)[12]
- 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 intervention.
- The root cause analysis utilizes:
    - Relevant clinical data
    - Input from the complex individual sub-population[13]

2. The network establishes a comprehensive care team

- The network develops a comprehensive care team capability that fulfills several functions[14] including:
    - Care management focused on engaging patients in better self-care[15]
    - Clinically focused care coordination
    - Community focused care coordination to link individuals to needed social services and supports as well as culturally and linguistically appropriate self-care management education.
    - The capability to add a Community Health Worker[16] on the comprehensive care team to fulfill community focused functions.

[11] See Appendix E for definition
[12] See Appendix F for examples of the type of criteria used in other models
[13] 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
[14] 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
[15] Models have demonstrated that embedding a designated care manager for complex patients into the care team to coordinate with the primary care team, practice personnel, and additional members of the team responsible for community and social services generates good results and is recommended where possible
[16] See Appendix E for definition; note CT AHEC CHW initiative is charged with creating a CHW Advisory Board that will be addressing the standards for CHWs, which many states have addressed through recognition of CHWs

    - Oversight and management of the comprehensive care team
- The network designates a lead care manager with responsibility for facilitating an effective comprehensive care team process and ensuring the achievement of the individual's lifestyle and clinical outcome goals.
- The network provides timely access to or has a comprehensive care team member who is a licensed behavioral health specialist capable of a conducting a comprehensive behavioral health assessment[17]
- The network adds comprehensive care team members outside of the above core functions (i.e.; dieticians, pharmacists, etc.) on an as needed basis depending on the needs identified in the person-centered assessment
- The network determines the best strategy for integrating additional comprehensive care team members. Options include:
    - Contracted or employed staff that reside within each primary care practice or in one or more hubs that support multiple practices
    - Coordination protocols for integrating affiliated clinical staff (e.g., specialists)
    - Contracted support from community organizations (e.g., CHW staff)
    - Collaborative agreements with clinical partners (e.g., home care)[18]
- The network establishes the appropriate case load (patient to team ratio) for comprehensive care teams[19]
- 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 additional members that form the comprehensive care team[20]
    - Basic behavioral health training appropriate for all comprehensive community care team members
    - Delivering culturally and linguistically appropriate services consistent with Department of Health and Human Services, Office of Minority Health, CLAS standards

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through certification or legislation. Connecticut has the opportunity to learn from other states, where they have embraced and incorporated CHWs as critical members of the health and human services team. Items for consideration include a widely accepted CHW definition, the scope of work, the various roles that CHWs fulfill, the training that is required/recommended, and credentialing. The preferred outcome is for CHWs to be recognized as valuable, sustainable members of health care and community teams. Metrics and evaluation of the impact of the CHW's intervention/s is important. The PMO will consider further the suggestion of establishing a Measurement Committee with the leadership of the CT AHEC CHW initiative.

[17] See Appendix E for definition

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

[19] Optimal ratios should be determined by the network based on local needs

[20] The PTTF 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

- The network develops and administers CHW training protocols or ensures that CHWs have otherwise received such training:
    - Person-centered assessment
    - 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[21]
    - 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 that are part of or engage with the comprehensive care team
    - On an annual basis to incorporate new concepts and guidelines and reinforce initial training

3. Connect individuals to a comprehensive care team

- The network implements a process to connect individuals to a comprehensive care team. Options for engagement with the individual include:
    - During the primary care visit
    - During an ED visit or inpatient hospital stay[22]
    - Pro-actively reaching out to the individual identified through analytics or registry data[23]

4. Conduct person-centered assessment[24]

- 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 includes[25]:
    - 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

[21] This includes common public health trends including the social determinants of health as well as awareness of conditions that are frequently unaddressed including reproductive health, oral health, behavioral health, etc.
[22] Networks could consider utilizing an ED/Inpatient technology that alerts the comprehensive care team upon admission and discharge of eligible individuals
[23] 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)
[24] See Appendix E for definition
[25] See Appendix B for an example of a needs assessment

  - Reproductive health needs
  - 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 defines:
  - Where the person-centered needs assessment takes place[26]
  - The timeframe within which the person-centered needs assessment is completed post-identification of individual need

5. Develop a comprehensive care plan[27]

- The comprehensive care team including the individual and their natural supports[28] collaborate to develop a comprehensive care plan[29] that reflects the person-centered needs assessment and includes the following features:
  - Reflects the individual's values, preferences, clinical outcome goals, and lifestyle goals
  - Establishes behavioral health goals to address existing mental health, substance abuse, or trauma needs
  - Establishes social health goals to address social determinant risk factors
- The network defines a process and protocol for the comprehensive care team to create the comprehensive care plan including location and timeframe for completion

6. Execute and monitor comprehensive care plan

- The network establishes protocols for regular comprehensive care team meetings that establish:
  - Who is required to attend[30]
  - 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 comprehensive care plan that includes:
  - Establishing key touch points for monitoring and readjusting of the comprehensive care 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 team[31]

[26] The PTTF believes this should be determined by the individual
[27] See Appendix E for definition
[28] Natural supports include but are not limited to, family, clergy, friends, and neighbors
[29] See Appendix F for an examples of person-centered care coordination plans
[30] Best practice suggests all members of the comprehensive care team and relevant primary care team members
[31] 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

- The network establishes a technology solution and/or protocols with local hospital and facility 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 coordination and care transitions[32]
- The network establishes a process and protocols for connecting individuals to needed community services (i.e.; social support services) which include:
    - See: *Community Health Collaborative* in Appendix C

7. Identify when the individual is ready to transition to self-directed care maintenance and primary care team support

- The comprehensive care team collaborates with the individual to assess readiness to independently self-manage and transition to routine primary care team support[33]
- 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 care team when needed

- The network establishes a mechanism to:
    - monitor and periodically re-assess transitioned individuals
    - notify the comprehensive care team when the individual has a change of condition or circumstances that require a reconnection to the comprehensive care team[34]

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:
    - Tracking aggregate clinical outcome, individual care experience, and utilization measures that are relevant to the focus population's needs (i.e.; complex individuals)[35]
    - 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 performance[36] data regularly with comprehensive care team members and other relevant care providers to identify opportunities for improvement

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[32] 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. Where possible treatment should be provided in the setting of the patient's choosing, often in the home, and providers should focus on increased communication with patients, including visits, in 24-48 hours post-transition with additional communication with providers post-transition.

[33] See Appendix F for sample tool

[34] The network could consider utilizing a ED/Inpatient admission/discharge alert technology for monitoring

[35] 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

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HEALTH EQUITY IMPROVEMENT
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 process 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, design and implement interventions, scale those interventions across networks, and evaluate the effectiveness of the intervention.

High-Level Process:

1. Analyze clinical performance or care experience stratified by sub-populations
2. Identify and prioritize opportunities to reduce a health care disparity
3. Implement an intervention to address the identified disparity
4. Evaluate whether the intervention was effective

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

- The network analyzes select clinical performance and care experience measures stratified by race/ethnicity, language, and other demographic markers including sexual orientation and gender identity
  - 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 measures aligned with the CT SIM quality scorecard[37]
    - Additional measures are quantifiable and address outcomes rather than process whenever possible.
    - Measures should meet generally applicable principles of reliability, validity, sampling and statistical methods.
- The network establishes methods of comparison between sub-populations
  - Clinical outcome and care experience measures are compared internally against the networks attributed population or to a benchmark[38]

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[36] 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

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

[38] 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.

    - 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.
    - 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 identified disparity[39]

- 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 focus sub-population for whom a disparity was identified
    - Input from the focus 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 in the design of the interventions
- The network includes a Community Health Worker as a component of their intervention[40]
    - 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 whether the intervention was effective

- The network demonstrates that the intervention is reducing the health care disparity identified by:

[39] The technical assistance vendor will be responsible for ensuring the networks are familiar with the science of improvement, change management, and performance measurement. The vendor will work with the providers to ensure that the interventions are tested for effectiveness with an accepted methodology (e.g., PDSA) before implementing and scaling. The technical assistance vendor will work with the PMO and the providers to identify opportunities to aggregate and report data on the effectiveness of these interventions to promote the population health goals of Connecticut.

[40] 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.

  - Tracking aggregate clinical outcome and care 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 measures for the interventions pursued
  - Establishes a method to share performance[41] regularly with relevant care team participants to collectively identify areas for improvement

FOCUS 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 FQHC 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 focus 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-

[41] 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

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 CHW[42]
- 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

[42] Optimal ratios should be determined by the network based on local needs

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- The network develops and administers CHW training protocols or ensures that CHWs have otherwise received such training:[43]
    - Person-centered assessment and support
    - Disease specific training informed by endorsed training protocols [44]
    - 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)
    - 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 focus sub-population 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 assessment[45]

5. Create a self-care management plan

- The CHW and the individual and their natural supports[46] collaborate to develop a self-care management plan that includes the following features:

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[43] 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.
[44] The disparity gap being addressed will determine the type of disease-specific training
[45] 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

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  - 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 change[47]
  - 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 date[48]
- The network defines a process and protocols for the CHW to create the person-centered self-management plan including location and timeframe for completion[49]

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 attend[50]
  - 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 risks[51]
- 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 support[52]
- The network develops a process and protocols for connecting individuals to needed community services (i.e. social support services) which include:
  - See Community Consensus Linkages Process and Guidelines

[46] Natural supports include but are not limited to, family, clergy, friends, and neighbors
[47] 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
[48] See Appendix F for examples from other programs
[49] 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
[50] Best practice suggests the following attendees: CHW, CHW field supervisor, key members of the primary care team, including the primary care provider
[51] 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
[52] 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

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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
    - Assessing achievement of individual identified care goals

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BEHAVIORAL HEALTH INTEGRATION
FOCUS POPULATION: PATIENTS WITH UNIDENTIFIED BEHAVIORAL HEALTH NEEDS
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 needs[53]

- 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 degree[54] 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 own[55]

[53] The screening is not intended to identify individuals with severe and persistent mental illness
[54] 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.
[55] 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 assessment[56] 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 visit[57]
- 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 considers[58]:
    - 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.[59]
- Primary care providers providing behavioral health care will have behavioral health training that covers:
    - Behavioral health promotion, detection, diagnosis, and referral for treatment[60].

[56] The assessment should reflect the needs identified by the screening tool.

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

[58] 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.

[59] 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).

[60] 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.

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- 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 include[61]
    - Guidelines on how information will be exchanged and within what timeframe
    - Designating an individual to be responsible for tracking and confirming referrals[62]
    - Developing technology, if possible, to alert the primary care practice when a referral is completed
    - Defining a timeframe within which a referral should be completed[63]
    - Appropriate coding and billing[64]

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 includes[65]:
    - Who is responsible for updating
    - Defining intervals at which assessments are made
    - Adjusting treatment when not effective

[61] 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)

[62] Consider a designated behavioral health referral coordinator

[63] Completed means the consultation occurred and information on the consultation was shared with the primary care practice

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

[65] Consider technological solutions for tracking outcomes such as a disease registry

Appendix B: Community & Clinical Integration Program – Elective Standards

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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 assessment[66] 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 applicable[67]
  - Oral dryness, pain and bleeding in the mouth
  - Oral hygiene and dietary habits
  - Need and expectations of the patient
- 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 examination[68] procedure of the entire oral cavity that includes:

[66] See Appendix F for a link to sample risk assessments

[67] 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: Connecticut Dental Health Partnership (CTDHP) Dental Home Definition)

  - Assessment for signs of active dental carries (white spots or untreated cavities)
  - Poor oral hygiene (presence of plaque, or gingival inflammation
  - Dry mouth (no pooling saliva and/or atrophic gingival tissues)
  - Pre-cancer and cancerous lesions
- The network determines who is responsible for conducting oral exam[69] and ensures appropriate oral health training and education[70] 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 individual[71]
- 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 setting[72]

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 care[73]
- The networks provides prevention education and materials in the primary care setting, ideally by a trained health educator or care manager[74], that includes:
  - Providing free products that support dental hygiene (e.g., toothbrush, floss, etc.)[75]
  - Using the built in EMR tools that provide standardized education to the individual based on diagnosis

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[68] See Appendix F for sample Oral Exam

[69] 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

[70] See Appendix F for possible training and education tools

[71] 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)

[72] 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

[73] 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

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

[75] The CTDHP can be a resource for this – will provide dental referral information and may issue free oral health products for Medicaid patients https://www.ctdhp.com/ or 1-855-CT-DENTAL

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    - 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
    - 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 providers[76]
    - Designating an individual to be responsible for tracking and coordinating referrals, confirming that the dental appoint 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 items[77]:
    - 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

[76] Networks should consider technologies such as direct messaging or secure messaging

[77] 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

ELECTRONIC CONSULTS (E-consults) STANDARDS

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

Program Description and Objective:

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

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

High-Level Program Design:

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

Detailed Program Design:

Standards

1. Identify individuals eligible for e-consult

- The network defines for which specialty they will do e-consults[78]
- The network involves the individual in the decision to utilize an e-consult and will send e-consults for all individuals who require the service of the designated specialty and who assent to e-consult, with the exception of individuals with urgent conditions and those who have a pre-existing relationship with a specialist

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

- The network designates with which specialty practice or specialty providers it will coordinate e-consults[79].

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

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

- In partnership with the specialty practice and/or providers, the network develops a standardized referral form that includes:
    - 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 e-consults to the specialty practice and/or providers designated to do e-consults[80]
- The network develops a process and protocol to send e-consults to the designated specialty practice and/or providers that includes:
    - Identifying an individual in the primary care practice responsible for sending the e-consult to the specialty practice and/or providers
    - Setting a timeframe within which the e-consult should be sent post-primary care visit
    - Establishing a payment method for the e-consult service[81]
- The specialty practice and/or provider develops a process and protocol to receive and review the e-consult that includes:
    - Identifying a coordinator whose responsibility it is to receive and prepare the consult for review
    - Setting a timeframe within which the e-consult has to be reviewed once received by specialty practice

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

- The specialist triages the referral into one of three categories:
    - 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 e-consult outcomes that include:
    - Setting a timeframe within which the specialist notifies the primary care practice of e-consult result regardless of the outcome

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

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

- 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
- 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 MANAGEMENT INTERVENTION

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

Program Description and Objective:

Description: The Comprehensive Medication Management (CMM) intervention will be an elective CCIP capability for patients with complex therapeutic needs who would benefit from a comprehensive personalized medication management plan. CMM is a system-level, person-centered process of care provided by pharmacists to optimize the complete drug therapy regimen for a patient's given medical condition, socio-economic conditions, and personal preferences. The CMM evidence-based model, according to 13 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."[82] In the context of CCIP, this intervention will be relevant for all patients who are experiencing difficulty managing their pharmacy regimen, who have complicated or multiple drug regimens, or who are not experiencing optimal therapeutic outcomes; this includes patients enrolled in CCIP with complex conditions and patients experiencing equity gaps.

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

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 intervention[83];
- The network develops a process for the responsible professional and/or care team to assess patient medication therapy management needs[84]

[82] American 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.

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

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.[85]
    - 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 includes[86]:
        1. Clinical training to support more effective patient engagement during one-on-one patient interactions
        2. Valid credentials[87]
        3. Interdisciplinary team work training to interact and work collaboratively with primary and comprehensive (should be aligned with team based training for comprehensive care team)
- The pharmacist conducts the initial consult in person[88].

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:

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

[85] 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

[86] 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.

[87] Networks should determine the appropriate credentials for CMM services. CT has addressed pharmacist competencies with a State regulation for Collaborative Drug Therapy Management (CDTM). It is recommended that networks adopt CDTM as minimum credentials for pharmacists providing CMM services. The CDTM regulation can be found here: http://www.healthreform.ct.gov/ohri/lib/ohri/work_groups/practice_transformation/reference_library_/ct_cdtm_regs_2012.pdf.

[88] For patients participating in the CCIP Complex Care program, this consult should occur in conjunction with the initial comprehensive care team person-centered assessment and/or care planning meeting, while other patients should schedule a consult with the pharmacist within a specified timeframe post-identification of the need for CMM. For less complex patients and subsequent consults, telehealth, telephonic, or other touch points may be advisable.

  - Create a comprehensive list of all patient medications including currently prescribed medications and any nonprescription nutritional supplements, vitamins, herbal products, and over-the-counter medications
  - Assess each medication for appropriateness, efficacy, safety, and adherence/ease of administration given a patient's medical condition and co-morbidities.
  - This assessment will be person-centered and also take into account the compatibility of medication with the individual's cultural traditions, personal preferences and values, home or family situation, social circumstances, age, functional deficits, health literacy, medication concerns, lifestyle, and financial concerns including affordability of medications compared to other regimens that achieve the same medical goals.
- The person-centered medication action plan includes:
  - An updated and reconciled medication list with information about medication use, allergies, and immunizations
  - Process to engage patients and their caregivers on better techniques to adhere to the therapeutic regimen 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 CMM intervention, frequency of interactions between pharmacist and patient throughout the intervention, and instructions on follow-up with the pharmacist, comprehensive care team, primary care team, and specialists as needed[89].
  - 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 assessment[90].
    - Developing technological capabilities for specified individuals to have access to the person-centered medication action plan

[89] 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.
[90] If the patient has a comprehensive care team or is working with a Community Health Worker, those individuals should also have access.

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 plan[91]
    - 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

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[91] 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 C: Community & Clinical Integration Program – Community Health Collaboratives

[TO BE ADDED]

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Appendix D: Response to Questions Pertaining to Core Standards

Individuals with Complex Needs

The PTTF considered the following questions drawing on best practices identified in related state and national programs and their individual expertise and experiences as providers, payers, and consumers of healthcare in Connecticut.

Review of State and National Programs

The PTTF considered several models across the country with the similar objective of transforming how healthcare 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 high-needs patients 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:

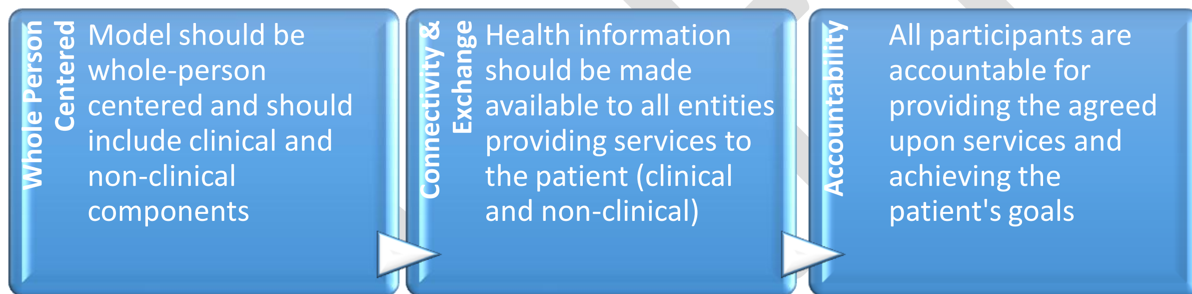
#	Design Feature	Examples
1	Careful definition of the focus population	• NY Health Home: Intensive care management to "high-need" individuals • Rhode Island Health Home: Adult behavioral health needs
2	Design of services to meet the needs of the focus population	• Hennepin: care team supporting patient 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	• 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	• Multiple Health Homes: set clear

	community-based organizations	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	• 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 PTTF attempted to replicate that balance of providing evidence-based standards for CCIP interventions with flexibility to cater to local needs.

The PTTF'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:



Response to Design Questions

1. How should networks identify complex patients?

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

- Physician referral
- Individually selecting patients in the primary care or acute setting after displaying certain "warning signs"
- Basic analytics that identifies patients based on level of risk (risk stratification)
- Advanced analytics to predict who is at risk of poor outcomes (predictive modeling) (Depriest A, 2015) (see Appendix E for definitions).

The analytics may be based on claims data, EHR data, or a combination of the two. EHR data provides the advantage of including real time clinical information such as a change in conditions, lab values, diagnostic tests and procedures. Regardless of the method used, the most important elements in identifying complex patients are a combination of clinical, social, and behavioral risk factors along with service utilization. Clinical and social factors should include any physical, functional, or cognitive challenges that are not otherwise identified as medical conditions.

While predictive analytics using a combination of EHR and claims data is the most advanced approach to identifying complex patients, PTTF members thought it likely that many of the Advanced Networks and FQHCs in Connecticut do not have that capability today. It is assumed that they will have access to claims data through Medicaid and private payers to do some basic utilization-based risk stratification. Taking this into consideration, the PTTF determined that the networks should use basic analytic tools to do risk stratification that accounts for utilization and the clinical, social, and behavioral risk factors as indicated in the claims data while attempting to progress toward more advanced predictive analytics as technology and capacity allow.

2. Who are the core members of the comprehensive care team be? What are their roles?

The care management teams across the programs that we reviewed are tailored to meet the needs, preferences, values, lifestyle, and goals of their patients. For this reason, these teams may vary in membership. 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 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 PTTF agreed that these roles should be core to the CCIP complex patient intervention. The PTTF also agreed that the initial needs assessment must take into account patient and caregiver input, thereby informing whether additional team members/functions should be added and/or made available when needed (e.g., a pharmacist or dietician). Given the common occurrence of behavioral health needs amongst complex patients (Brown D, 2014), the PTTF felt strongly that the team should either have a team member who is also a licensed behavioral health care specialist or, at a minimum, should provide timely access to a licensed behavioral health care specialist.

Aside from the behavioral health specialist, the PTTF elected not to require specific credentials for any of the care team members. The PTTF 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 re-purpose current employees to fulfill the CCIP requirements, the PTTF decided that the care management, care coordination, and overall management function can be fulfilled by any individual with training in that area and that there should be a dedicated care manager for each patient. However, the PTTF will not require that the individuals have a specified set of credentials. Given the unique role of the Community Health Worker (CHW, see Appendix E 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 be expected to develop written job descriptions outlining how each member will fulfill their specified function.

3. How will the network engage the necessary workforce?

Advanced Networks and FQHCs participating in CCIP will likely vary in their readiness to enable comprehensive care teams. Some networks will already have the staff resources for a comprehensive

care team in place, but these teams may be organized differently around the patient. The networks will also vary in structure. Some networks will be vertically integrated with other healthcare 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 PTTF agreed that the strategy chosen to build the comprehensive care teams and how they are operationalized should be decided by the networks.

Since the CHW will be the one key care team member less likely to be employed today, the PTTF felt that the decision as whether to employ or contract for these services should be left up to the network. Regardless of this decision, the key responsibilities of the CHW should be made explicitly clear. Similarly, the PTTF also encourages networks to determine an appropriate and manageable caseload for the comprehensive care team to ensure effective deployment of that team. 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 care team members require?

Existing programs focus training on team-based care and the associated work-flow redesign. Assembling a comprehensive care team to provide care management will either introduce new positions that did not previously exist or re-define the scope of work of existing team members. 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 (CHW). 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, including: how to build trusting relationships, how to identify patient behavioral and social needs and connect individuals to relevant supportive services, how to provide health education to support behavior change, and how to advocate on behalf of the individuals whom they support (Boston, 2007).

Better integrating primary care with community care through the use of a comprehensive care team may be a paradigm shift for many primary care practices. Team-based training that supports this shift and clarifies roles and responsibilities for providers participating in the new care model should be required. In addition, the PTTF 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 PTTF noted that many complex patients will have behavioral health needs and represent a variety of cultural backgrounds. Accordingly, the PTTF recommended 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? How will they be administered?

Needs assessments across programs may be as simple as a brief intake form (Coalition, 2015) to involving complex eco-mapping with 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, an effective process should 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 the patient and may also include the input of their natural supports (see Appendix E for definition) and caregivers to address health needs. Care plans should clearly articulate the patient's goals, who on the care team is responsible for supporting the patient to meet those goals, timeframes for achieving the stated goals, and the patient/caregiver responsibilities for improving self-management (Coalition, 2015) (Kansas Medicaid, 2015). The person-centered care plan is intended to be incorporated into the primary care setting with the comprehensive care team coordinating to address the individual's non-clinical needs.

The PTTF 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 PTTF was primarily concerned that the standards around the needs assessment and care plan be person-centered. In addition to recommending standards for needs assessments and care plans in line with other programs, the PTTF articulates standards for how the Advanced Networks and FQHCs can ensure person-centered orientation of the needs assessments and care plans. The most important factor to ensure person-centered orientation of that assessment is the patient's input into what programmatic features will work best given cultural, linguistic, and other preferences. The person-centered orientation of the assessment and corresponding plan explicitly connects patient needs with non-clinical services and the patient's stated clinical outcome and lifestylegoals.

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

Examples from models across the country show that some care teams maintain defined schedules for checking in with the patient as well as mechanisms to connect with individuals when additional support is needed (Coalition, 2015). Meanwhile, others frequently check in with patients in a less formalized manner as needed to support carrying out the care plan (Takach M, 2013) (DiPietro, 2015). The most important components to successful care coordination include: (1) engaging the patient to determine satisfaction and comfort with the care plan; (2) the regular monitoring of care plan progress with both the patient and other providers; and (3) frequent communication with the clinical and non-clinical service providers touching the patient 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 individual and their families and other care team members; (2) within the care team and needed social support services; and, (3) across the entire spectrum of services and supports to enable effective transitions of care (Agency for Healthcare Research and Quality, 2012). This is facilitated by frequent check-ins with the patient to monitor their progress according to the patient's wishes, but technology solutions can also support the seamless communication of pertinent healthcare information between care teams across the healthcare continuum. Regardless of the technology solutions, more formal

linkages should be developed between clinical and non-clinical service providers in terms of familiarity of the other organization's mission, structure, and processes (Takach M, 2013) (The Center for Health Care Strategies, Inc., 2014).

The PTTF felt it important for teams to 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). This allows for consistency from both the patient's and provider's points of view to engage one another. It also provides additional support for the patient to seek assistance when needed. Additionally the PTTF felt it important to establish standards supporting seamless communication through technology and for the networks to create linkages to community resources. However, the PTTF 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. Because of the variation in needs, resources, and preferences, the PTTF decided that establishing better integration of shared community resources should happen at a broader network level, not only in relation to the focus populations[92].

7. How can networks monitor an individual's health status after they transition to self-directed care management?

Many of the programs reviewed did not have specific mechanisms in place to monitor individuals after they move to more self-directed care management and assume more responsibility for their own care plan. However, many care management teams express a desire for a mechanism to alert them to a patient in crisis either through the individual reaching out to the care team or via statewide technology (e.g., an admission discharge and transfer system – see Appendix E for definition). In this case, 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 technology mechanisms around these types of alerts, the PTTF 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). The PTTF therefore suggested that the networks work with Peer Support specialists (see Appendix E for definition) to support individual transitions and serve as the contact if there is a need to reconnect to the comprehensive care team. In addition, the networks will be required to develop processes related to monitoring mechanisms for these patients who are self-managing their care so the care team can be alerted that an individual may be in crisis.

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

Care teams are often embedded in broader programs, which has complicated the monitoring of the effectiveness of care management programs. For example, Vermont's Blueprint for Health recently compared outcomes of different primary care practices between practices that have a Community

[92] Please see section on Community Consensus & Linkages for Community Health Board standards for further explanation of rationale and context.

Health Team (CHT)—Vermont's version of a comprehensive care team—and practices without a CHT to assess its effectiveness. However, the study could not attribute the improved outcomes to the CHT. 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 PTTF felt that monitoring the effectiveness of the CCIP interventions should incorporate both an assessment of the 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 PTTF 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 PTTF felt that learning collaboratives across practices could be a useful tool in reporting effective care management protocols. These types of collaborative efforts have been effective in other programs, such as the Camden Coalition, for identifying improvement opportunities.

9. How will patient and caregiver preferences and input be incorporated into the care plan?

There are several ways that care teams across the country engage patients and caregivers to incorporate their preferences into the care plan. The most important factor in successful patient and caregiver engagement is ensuring that the providers interacting with the patient are capable of communicating in a manner that is culturally sensitive, that is easily understood (e.g., avoiding overly "medicalized" terminology regarding care plans, diagnosis, and treatment), and that encourages the patient to reflect on their own goals and values. Many of these skills are learned over time. And, as the networks will be starting from different points in terms of resources and capabilities, the PTTF is not suggesting specific training programs. The PTTF is, however, recommending that each network determine how it can best train its providers to engage patients and caregivers appropriately.

In addition, the PTTF recommends building in certain processes and markers to flag patient and caregiver preferences for each provider that accesses the patient's record. Some programs place the patient's goals and preferences at the very top of the care plan so that it is the first thing providers see. Whatever the mechanism, the PTTF strongly urges networks to identify whatever mechanism works best given their resources and capabilities so that patient/caregiver preferences are known and respected.

Patients Experiencing Equity Gaps

The PTTF considered the best practices emerging from other CHW programs and research trials in addition to members' expertise and experiences as providers, payers, and consumers of healthcare in Connecticut.

1. How will the network build the CHW workforce?

The randomized controlled trials that have tested the use of CHWs to provide more culturally sensitive 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

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with chronic illnesses, etc.). To adhere to the protocols of a research study, the CHWs were often deployed to the practices or hospitals for a limited time period to conduct the study versus having the CHWs permanently employed by the provider. Since CCIP is a longer-term intervention, 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, 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).

Some studies also 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 PTTF 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 PTTF 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 PTTF 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. These communication methods enable the CHW to interact with patients in a way that positively engages them as partners in their own healthcare.

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).

The PTTF therefore recommends these basic criteria, but it also encourages the incorporation of social or behavioral risk factors and health literacy and/or language barriers. Consistent with the goals and objectives of CCIP, many sub-optimal health outcomes are directly related to these non-clinical factors, and the PTTF encourages networks to engage their communities to identify those factors that may be contributing to those care gaps. The transformation vendor and the Community Health Collaborative efforts can play a role in engaging those key community resources to determine the social or behavioral risks prevalent in the community. 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). The PTTF also strongly encourages engaging the patients and caregivers to incorporate personal preferences and values as well

as family, social and cultural characteristics. This is the only way to ensure person-centeredness and will be a major driver in ensuring success.

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 to support the individual in gaining needed self-care management skills. As with any care plan it is informed by the needs assessment, the personal preferences, values, and goals of patients and caregivers, 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 patients with complex needs 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 by making it clear within the standards that the plan must be developed in collaboration with the patient to 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. The plan will then be incorporated into the primary care plan and the plan of care coordinated with the primary care provider.

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 PTTF 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 in consultation with the patient according to their preferences and any social or cultural traditions.

As with the patients with complex needs, seamless communication is required for between the individual's primary care team, the CHW, and any relevant social support services. The PTTF acknowledged and recommended the need for a technological solution to solve for seamless communication, but it did not specify what that solution should be.

The Community Health Collaborative standards of CCIP will help to develop relationships with social support services to aid the CHWs in seamlessly connecting individuals to needed support.

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Patients with Unidentified Behavioral Health Needs

In answering the following questions, the PTTF 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 and patient representatives in the state.

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. The PTTF requires 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 PTTF wanted to provide networks the freedom to choose any standardized and validated tool for other behavioral health needs for two reasons: (1) Outside of depression there are no tools nationally recognized as being the “gold standard” for screening, and the data gained from networks over time implementing different screening tools may provide useful insight into a future standard; and, (2) Different tools may be more prone to self-administration than others. The BHDG and PTTF 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 PTTF also felt it was important to note that the screening tool is intended solely to flag potential 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. The PTTF recommended that 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 to align with the SIM 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; (2) the comfort level of the primary care provider in managing the condition and the medication regimen; and (3) the patient/caregiver’s comfort level, ability, and preference on treatment location. When it is possible that the individual be treated in either the primary care or a behavioral health care setting, the BHDG and PTTF believe that networks should focus on the individual’s choices and preferences, engaging the patient to ensure that they have the adequate education and support to make that decision.

Regardless of whether or not individuals are provided behavioral health care within the primary care setting or referred elsewhere, the PTTF 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, patient engagement, 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?

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The BHDG and the PTTF recommends that the Advanced Network/FQHC execute at least one Memorandum of Understanding (MOU) with a behavioral health clinic and/or practice to promote accountability. Both providers are thus required to follow the MOU specified protocols and processes. The BHDG and PTTF also recommends 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 PTTF recommend that the MOU and other agreements specify three things: (1) how relevant health care information will be exchanged between the primary care providers and the behavioral healthcare providers; (2) an individual responsible for tracking the referral; and (3) exploring technological solutions to automate confirmation that a referral has been completed. The BHDG and PTTF also recommend that the behavioral health provider make the care plan available to the primary care provider to be incorporated into the primary care electronic medical record. The care plan should specify what role the primary care provider can play in the care plan.

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Appendix E: Definitions

Community Health Worker: A frontline public health worker who is a trusted member of the community or has an excellent understanding of the community served. This trusting relationship allows the worker to serve as a link between health/social services and the community to help people access services and be sure that services are offered in the person's language and respectful of their cultural beliefs.

Community Linkages: Standardized processes for the seamless coordination, communication, and integration of a community of clinical health service providers with social services and supports to address the range of healthcare and socio-economic patient needs that contribute to health outcomes.

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

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

High Needs Patient: Individuals whose complex medical conditions are often compounded by physical, behavioral, environmental, oral health, or socioeconomic factors that are not well managed by the current healthcare system. As a result these individuals have frequent ER visits, hospital admissions or re-admissions due to unresolved, often preventable complications that drive up healthcare costs and result in poor patient outcomes.

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 (Medicaid, 2015).

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

Patients Experiencing Equity Gaps: Individuals belonging to a sub-population experiencing poorer health outcomes in a specific clinical area (e.g., diabetes).

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

Peer Support Specialist: A person who uses his or her own life experiences to provide counseling and support services to an individual.

Person-Centered: Person-centered care engages patients as partners in their healthcare and focuses on the individual's choices, strengths, values, beliefs, preferences, and needs to ensure that these factors guide all clinical decisions as well as non-clinical decisions that support independence, self-determination, recovery, and wellness (quality of life). The individual engages in a process of shared-decision making to make informed decisions about their care plan and treatment. The individual 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.

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

Person-Centered Care Coordination Plan: A written 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's health care issues complex, as defined by the Practice Transformation Taskforce (PTTF). The PTTF 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 insurance payers and providers.

Value Based Insurance Design: Insurance plans that encourage 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 of visits and services. 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 F: 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-intervetions/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

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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: ____/____/____

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.
*If any category has a score of 1 or 2, please arrange for the patient to be examined by a dentist.

Category	0 = healthy	1 = changes *	2 = unhealthy *	Category scores
Lips	Smooth, pink, moist	Dry, chapped, or red at corners	Swelling or lump, white/red/ulcerated patch; bleeding/ulcerated at corners	
Tongue	Normal, moist, roughness, pink	Patchy, fissured, red, coated	Patch that is red and/or white, ulcerated, swollen	
Gums and tissues	Pink, moist, smooth, no bleeding	Dry, shiny, rough, red, swollen, one ulcer/sore spot under dentures	Swollen, bleeding gums, ulcers, white/red patches, generalized redness or ulcers under dentures	
Saliva	Moist tissues, watery and free-flowing saliva	Dry, sticky tissues, little saliva present	Tissues parched and red, very little/no saliva present, saliva very thick	
Natural teeth Yes/No	No decayed or broken teeth/roots	1-3 decayed or broken teeth/ roots or teeth very worn down	4 or more decayed or broken teeth/roots, or fewer than 4 teeth, or very worn down teeth	
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	More than 1 broken area/tooth, denture missing or not worn, needs denture adhesive	
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 pulling at face, chewing lips, not eating, aggression	Physical signs such as 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	

☐ Arrange for patient to be examined by a dentist.
☐ Patient or family/guardian refuses dental treatment.
☐ Review this patient's oral health again on (date): ___/___/___

TOTAL SCORE: 16

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)

Compiled by Dolce and Bowser November, 2013

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

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	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

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Appendix G: Interviewee List

Interviewee(s)	Topic(s)
Pat Baker & Elizabeth Kraus, Connecticut Health Foundation	• Measuring Health Equity Gaps • Community Health Workers
Bernadette Keleher	• Community Linkages
Bruce Gould and Petra Clark Dufner, UCONN Health/AHEC	• Community Health Workers
Camden Coalition	• Community Health Workers • Identification of complex patients
Terri DiPietro, Middlesex	• Identification of complex patients
Suzanne Lagarde, CEO Fair Haven Community Health Center	• E-consults
Steve Ruth, Systems and Management Consulting	• Care Transitions
Primary Care Coalition of Connecticut	• Identification of complex patients • Community Linkages • Care Transitions
Grace Damio, Hispanic Health Council, Director of Research and Training	• Community Health Workers
Dawn Lambert & Kate McEvoy, DSS	• Long Term Support Services
Daren Anderson, Community Health Center, Inc.	• E-consults
Molly Gavin, CT Community Care, Inc.	• Long Term Support Services
Center for Healthcare Strategies	• Identification of complex patients • Identification of equity gaps • Dynamic Clinical Care Teams • Community Health Workers • Community Linkages
CT SIM State Program Experience (CMMI Support)	• All

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