DRAFT


# Healthcare Innovation Steering Committee

## Special Meeting:

## Community & Clinical Integration Program

## March 30, 2016

# State Innovation Model

***Connecticut will establish a whole-person centered healthcare system that will…***

- Improve Population Health
- Promote Consumer Engagement
- Reduce Health Inequities
- Improve access, quality and patient experience
- Improve affordability by lowering costs

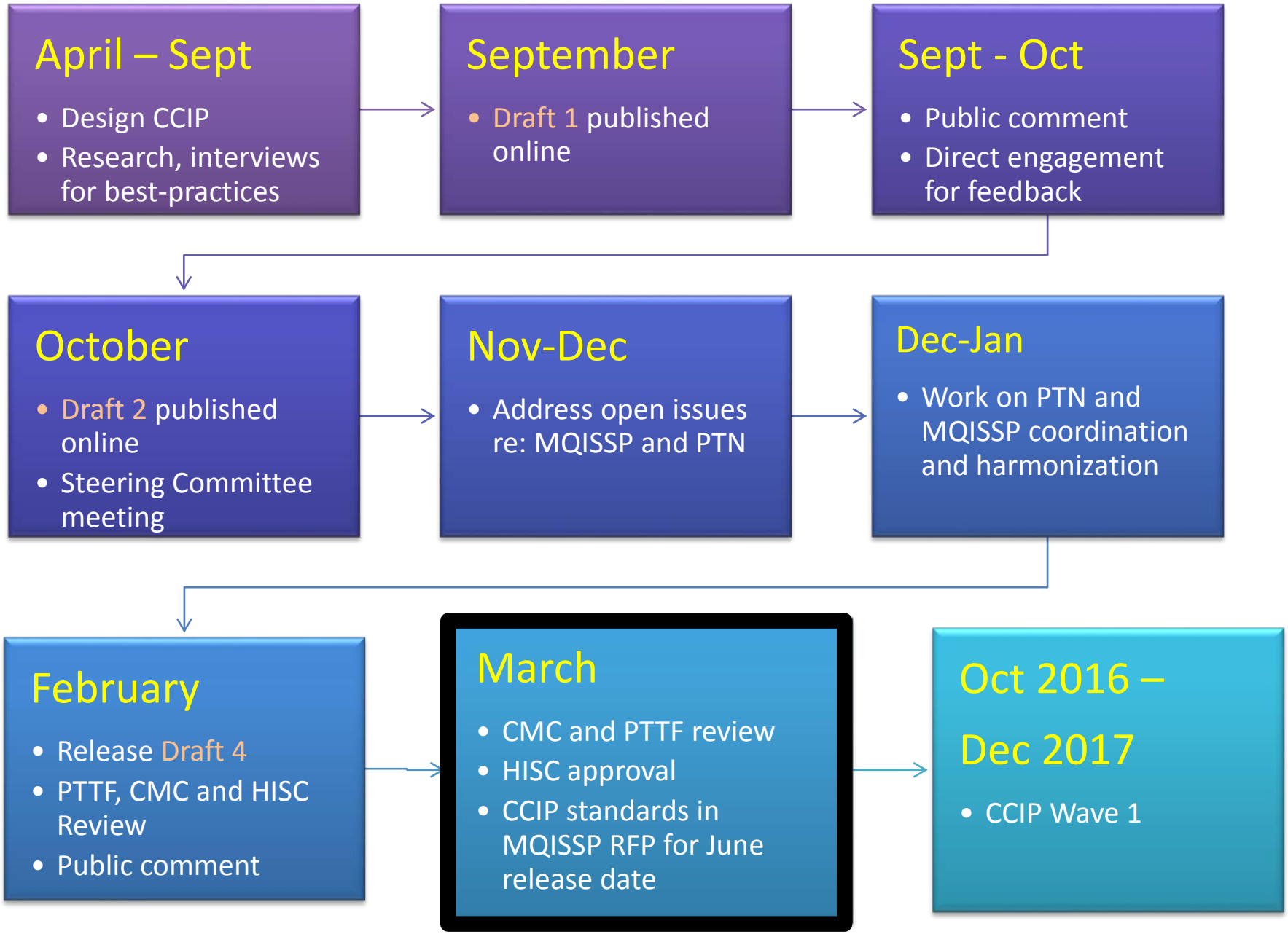
# Meeting Agenda

| Item | Allotted Time |
| --- | --- |
| 1. Introductions | 5 |
| 2. Minutes | 5 |
| 3.Purpose of Today's Meeting | 5 |
| 4. CCIP Report & CCIP Standards: Edits | 40 |
| 5. Next Steps | 5 |

# Purpose of Today's Meeting

- Discuss edits to the report and standards recommended by the PTTF in response to comments of the public and the Care Management Committee of the MAPOC
- Approve CCIP Final Report (Draft 5) which will reflect discussed edits

# CCIP Design High-Level Timeline



# ADJUSTMENTS TO THE CCIP IMPLEMENTATION STRATEGY

# CCIP Implementation Strategy

- DSS and the PMO have prepared a plan for coordinating the launch of MQISSP and CCIP
- DSS has agreed to embed requirements related to CCIP standards within the Request for Proposals (RFP) through which DSS will procure Participating Entities for the Medicaid Quality Improvement and Shared Savings Program (MQISSP)
- DSS' reason for doing so is that it acknowledges the value of promoting activities that will promote and support the needs of Medicaid beneficiaries who are already being served by advanced networks
- It will be useful to test the CCIP standards

# CCIP Implementation: Two Tracks

The DSS MQISSP RFP will offer **two tracks**, from which applicant entities must choose

- The **first track** will require Participating Entities to participate in CCIP technical assistance, but will not require demonstrated achievement of the CCIP standards as a condition for continued participation in MQISSP
- The **second track** will enable Participating Entities to indicate that they agree to be bound by CCIP standards. Only these entities will be eligible for potential transformation awards
- Over the course of the first MQISSP performance period, DSS and the SIM PMO will carefully review the experience of Participating Entities that agree to be bound by the CCIP standards, will seek additional comment on the CCIP standards, and may adjust the CCIP standards, as needed.
- For the second wave MQISSP procurement, achievement of the CCIP standards, as revised, will be a condition for all MQISSP Participating Entities, including those entities that were exempt during the first wave

# CCIP Implementation: Coordination with ICM Programs

- As Advanced Networks grow their care management capabilities, the following situations might occur:
  - Advanced Network identifies individuals for comprehensive care management who might otherwise have been identified and served by the CHNCT ICM Program,
  - Advanced Network identifies individuals for comprehensive care management who are already being served by the CHNCT ICM Program (or the opposite),
  - Advanced Network and CHNCT both identify the same high need individual at the same time.

# CCIP Implementation: Coordination Protocols

- Coordination Protocols: Advanced Networks and FQHCs participating in CCIP will be required to develop coordination protocols with CHNCT and Beacon Health Options that set mutually agreeable processes for handling coordination with the ICM programs. The protocols may specify, for example, how individual choice should factor into decisions about who leads the care management process and for which individuals one or another program might be better suited.

# CCIP Implementation: Accommodation

- Requirement Accommodation: Participants can request an exemption from or adjustment to a CCIP requirement that conflicts with, or would otherwise disrupt, their activities in relation to DSS programs such as PCMH or the CHNCT or Beacon Health Options ICM Program.
- Hardship Accommodation: Participants can request an accommodation if the costs associated with meeting a requirement presents an insurmountable barrier.
- Timetable Accommodation: Participating entities in Track 2 may request an additional 6-months to meet CCIP standards.
- Alignment Accommodation: Participants can request an accommodation if a requirement does not fully align with the Advanced Network's care delivery model and the needs of its patient populations.

# CORE STANDARD 1: COMPREHENSIVE CARE MANAGEMENT (CCM)

## EDITS

# Edit to CCM Standard 1: Identify individuals with complex health needs

a) The network identifies individuals with complex health needs who will benefit from the support of a comprehensive care team using an analytics-based risk stratification methodology **that identifies current and rising risk and** takes into consideration utilization data (claims-based); clinical, behavioral, and social determinant data (EMR-based); and provider referral. **Integration with and use of external data sources (e.g., Homeless Management Information System, state agency data) is also recommended.**

**b) Network has a process to electronically alert the medical home care team of the identified individuals with complex health needs that meet identified risk threshold.**

# Edit to CCM Standard 5: Execute & monitor individualized care plan

e. The network establishes a process and protocols for **accessing an up-to-date resource directory (such as United Way 211),** connecting individuals to needed community ~~**services**~~ **resources** (i.e.; social support services), **tracking referrals,** tracking barriers to care, and providing facilitation to address such barriers (i.e., rides to appointments).

# Edit to CCM Standard 4: Establish a Comprehensive Care Team

**Proposed edit to CCM Standard 4.d**

- The network ensures that each care team:
  - designates a lead care coordinator with responsibility for facilitating an effective comprehensive care team process and ensuring the achievement of the individual's lifestyle and clinical outcome goals.
  - has the capability to add a community health worker to fulfill community-focused coordination functions
  - has 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
  - adds comprehensive care team members outside of the above core functions (i.e.; dieticians, pharmacists, **palliative care practitioners,** etc.) on an as needed basis depending on the needs identified in the person-centered assessment

# CORE STANDARD 2: HEALTH EQUITY COMMENTS

# Race/Ethnicity Categories

**How do we ensure health systems are analyzing data and deploying interventions for populations that make up a small percentage of their panels, or are hidden within the broader OMB categories, but are experiencing substantial health disparities**

- *"A critical issue in race and ethnicity data collection is how many categories of race and ethnicity to include. Having every possible racial and ethnic category available in a data collection tool may be quite cumbersome and require sophisticated information technology. On the other hand, collecting data using very broad categories may not be useful for organizations serving very diverse populations. For example, the Asian category includes individuals from India, China, Korea and other countries with significantly different cultures and beliefs."*

  – RWJF

SIM Southeast Asian Listening Session revealed that members of the Southeast Asian community in Connecticut face specific healthcare challenges, including high rates of diabetes and hypertension

# Previous language

**Core Standard 2: Health Equity Improvement**

1. Expand the collection, reporting, and analysis of standardized data stratified by sub-populations

A. The network identifies valid clinical and care experience performance measures to compare clinical performance between sub-populations. Such measures:

**Ii. Include, at a minimum, Office of Management and Budget (OMB) race/ethnicity categories and preferred language in their EMR**

**Race**

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White

**Ethnicity**

- Hispanic or Latino
- Not Hispanic or Latino

# “Granular Ethnicities”

- The OMB categories are not sufficiently descriptive to distinguish among locally relevant ethnic populations that face unique health problems and may have dissimilar patterns of care and outcomes (Hasnain-Wynia and Baker, 2006) (Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement, Institute of Medicine (2009))

- OMB encourages **additional granularity** where it is supported by sample size and as long as the additional detail can be aggregated back to the minimum standard set of race and ethnicity categories (https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status)

# New ONC Requirement for Certified EHRs

**45 CFR Part 170**
**2015 Edition Health Information Technology (Health IT) Certification Criteria, 2015 Edition Base Electronic Health Record (EHR) Definition, and ONC Health IT Certification Program Modifications; Final Rule**

Race/ethnicity

- Requirement that allows provider to "record each one of a patient's races and ethnicities in accordance with, at a minimum, the ''Race & Ethnicity—CDC'' code system in the PHIN Vocabulary Access and Distribution System (VADS), Release 3.3.9 18 and aggregate each one of a patient's races and ethnicities to the categories in the OMB standard for race and ethnicity" (CDC list has 900+ categories)

Language

- In the Proposed Rule, we proposed to require the use of the Internet Engineering Task Force (IETF) Request for Comments (RFC) 5646 19 standard for preferred language

# Edit to Health Equity Improvement Standard

**Core Standard 2: Health Equity Improvement, Part 1**

1. Expand the collection, reporting, and analysis of standardized data stratified by sub-populations

   **a. Require that the network implement a plan to collect additional race and ethnicity categories for its patient population. The selection of additional categories must:**

      **i. Draw from the recognized "Race & Ethnicity—CDC" code system in the PHIN Vocabulary Access and Distribution System (VADS)) or a comparable alternative;**

      **ii. Have the capacity to be aggregated to the broader OMB categories;**

      **iii. Be representative of the population it serves, validated by (a) data (e.g., census tract data, surveys of the population) and; (b) input from community and consumer members if the network is implementing fewer than the 900+ available categories**

# Edit to Health Equity Improvement Standard

**Core Standard 2: Health Equity Improvement, Part 1**

1. Expand the collection, reporting, and analysis of standardized data stratified by sub-populations

   b. The network identifies valid clinical and care experience performance measures to compare clinical performance between sub-populations. Such measures:

   i. Maximize alignment with the CT SIM quality scorecard

   **ii. Include, at a minimum, the race/ethnicity categories identified in 1a. and preferred language.**

   iii. Are quantifiable and address outcomes rather than process whenever possible.

   iv. Meet generally applicable principles of reliability, validity, sampling and statistical methods.

ii. ~~Include, at a minimum, Office of Management and Budget (OMB) race/ethnicity categories and preferred language in their EMR~~

# Edit to Health Equity Improvement Standard

**Core Standard 2: Health Equity Improvement, Part 1**

1. Expand the collection, reporting, and analysis of standardized data stratified by sub-populations

   c. The network analyzes the identified clinical performance and care experience measures stratified by race/ethnicity, language, ~~**and**~~ other demographic markers such as sexual orientation and gender identity**, and geography/place of residence**

   d. The network establishes methods of comparison between sub-populations.

      I. Clinical outcome and care experience measures are compared internally against the networks attributed population or to a benchmark

      II. Stratification by race/ethnicity/**language** is informed by the demographics of the population served by the network

# Previous Language: Health Equity Intro

**Core Standard 2: Health Equity Improvement, Part 2, Introduction**

- For the pilot, networks will be encouraged to focus on sub-populations defined by large race and ethnic populations and one of three conditions (diabetes, hypertension and asthma) that are included in the SIM Core Quality Measure set. The network may propose an alternative area of focus based on the network's demographics and performance data. Networks are encouraged to pilot the intervention in at least five practices or a large clinic setting.

- **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.**

# Edit to Health Equity Improvement Standard

**Core Standard 2: Health Equity Improvement, Part 2, Introduction**

- For the pilot, networks will be encouraged to focus on sub-populations defined by **race, ethnicity, and or language** and one of three conditions (diabetes, hypertension and asthma) that are included in the SIM Core Quality Measure set. ~~The network may propose an alternative area of focus based on the network's demographics and performance data~~. Networks are encouraged to pilot the intervention in at least five practices or a large clinic setting.

- **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.**

# Edit to Health Equity Improvement Standard

**Edit to HE.Part 2 Standard 3. Identify individuals who will benefit from CHW support**

a. Network identifies individuals who will benefit from CHW support by developing criteria that assess whether an individual:

i. Is part of the focus sub-population for the intervention

ii. Has a lack of health status improvement for the targeted clinical outcome

iii. Has cultural, health literacy and/or language barriers

iv. Has social determinant or other risk factors associated with poor outcomes

**b. Network has a process to electronically alert the medical home care team of the identified individuals that meet identified threshold for health equity intervention.**

# CORE STANDARD 3: BEHAVIORAL HEALTH INTEGRATION

## EDITS

# Edit to Behavioral Health Standard Description

- Added to the description section of the behavioral health section that coordinating care for those with identified chronic behavioral health needs is critical and expected of networks. Clarify that CCIP standards focus on unidentified needs and primary care coordinated interventions in order to avoid duplication with existing programs for higher risk individuals (e.g., DHMAS Behavioral Health Homes).

# OTHER EDITS

# Other edits

SIM PMO released a response to comments that addressed other concerns and clarified some of the CCIP recommendations:

Response to comments

Summary of Response to Comments

- Added language from introduction of “Response to Comments” into Executive Summary of report
- Emphasized the importance of supporting the best interests of Medicaid beneficiaries
- Added description and list of Task Force membership
- Discussed coordination with DSS and community programs
- Discussed issues related to cost of meeting standards
- Discussed enforcement of standards
- Expanded on how standards were chosen

# NEXT STEPS

# CCIP Timeline