DRAFT AND PROVISIONAL – 4/11/2018

Standard 1: Comprehensive Care Management

Identifying and managing patients with complex healthcare needs is key to meeting quality and cost targets. Comprehensive care management is most effective when the primary care team uses additional staff to assess a cohort of identified patients, develop a care plan, and follow through to ensure the right care is provided.

This Standard identifies key components of an effective Comprehensive Care Management strategy. In order to achieve the Standard, your network must achieve the goals and demonstrate improvement on the process measures, as detailed below.

Goals:

Your network has a **clear, detailed, documented policy** for identifying patients with complex needs, developing individualized care plans, and connecting patients with a comprehensive care management team that effectively executes and monitors the care plans.

85% of the practices in your network have fully implemented the policy.

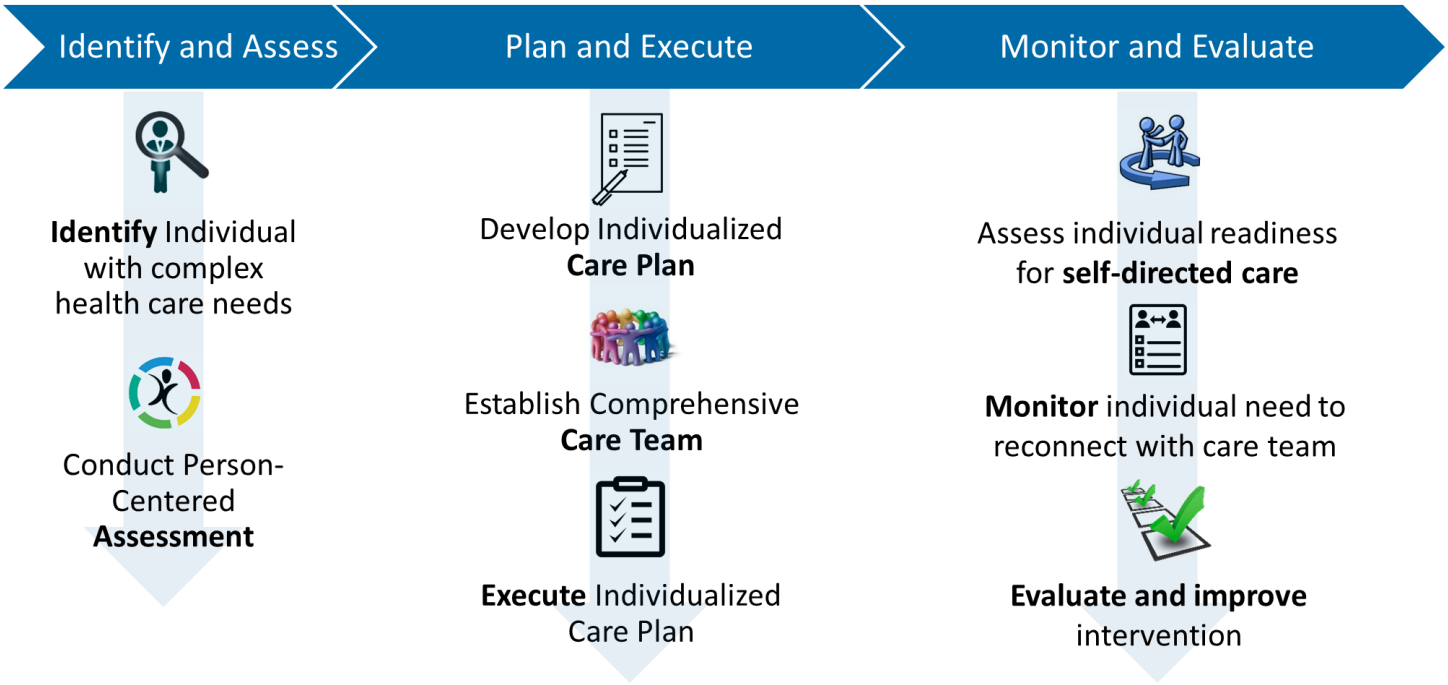
Process Measures:

1. Increase use of Person Centered Assessments (PCAs) with complex patients
2. Increase identification of Social Determinants of Health (SDOH) needs among high risk patients
3. Increase use of Community Health Workers (CHWs) for navigation and linkage
4. Increase use of Comprehensive Care Team

Outcome Measures:

1. Decrease hospital admissions, readmissions, and ED visits

Key Elements of Comprehensive Care Management



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Identify individuals with complex health care needs

1. Use analytics-based risk stratification to identify patients with current and rising risk based on:
   a. Claims-based utilization data
   b. EMR-based clinical, behavioral, and SDOH data
   c. Provider Referral
   d. External data, if possible (e.g., Homeless Management Information System)
2. Implement electronic alerts to inform medical home team of identified patients

Conduct Person Centered Assessment (PCA)

1. Conduct a Person Centered Assessment (PCA) with identified patients. Include:
   a. Preferred language (spoken and written)
   b. Family/social/cultural characteristics including sources of support
   c. Assessment of health literacy
   d. Social determinant risks
   e. Personal preferences, values, needs, and strengths
   f. Behavioral health needs, including depression and substance use
   g. Functional assessment
   h. Reproductive health needs
   i. Primary and secondary clinical diagnoses that are most challenging for the individual to manage
2. Establish a policy:
   a. **Where** PCA occurs
   b. **When** PCA is completed
   c. **Who** conducts PCA

Develop Individualized Care Plan (ICP)

1. Develop Individualized Care Plan (ICP) through collaboration with patient and their natural supports. The ICP should:
   a. Reflect the individual's values, preferences, clinical outcome goals, and lifestyle goals
   b. Establish physical and behavioral clinical care goals
   c. Establish social health goals
   d. Identify referrals necessary to address goals and a plan for linkage and coordination
2. Establish a policy:
   a. **Where** ICP is developed
   b. **When** ICP is developed
   c. **Who** develops ICP
   d. **How often** ICP is updated

Establish Comprehensive Care Team

1. Develop a comprehensive care team capability that specifically addresses the individual needs of the patient in accordance with the ICP. The Care Team should:
   a. Designate a lead care coordinator
   b. Add a Community Health Worker to the team for individuals with identified need for navigation, coaching, or linkage to community services and supports.
   c. Add a Licensed Behavioral Health Specialist (whether community based or part of the AN/FQHC) to the team for individuals with identified behavioral health needs.
2. Establish a policy:
   a. **When** individual is connected to Care Team (e.g., during primary care or ED visit)
   b. **Who** connects individual to Care Team
   c. **Who** is part of the Care Team

   d. **How** additional Care Team members are integrated (i.e. direct employment, contractual, collaborative)
   e. **How many** patients Care Team can manage (case load)
3. Establish annual training to successfully integrate and sustain comprehensive care teams.
   a. Orient primary care team to the roles and responsibilities of additional care team members
   b. Identify values, principles and goals of the comprehensive care team intervention
   c. Provide training to all care team members in:
      (1) Basic behavioral health integration
      (2) Motivational interviewing (required for the care coordinator, recommended for others)
      (3) Delivering culturally and linguistically appropriate services consistent with Department of Health and Human Services, Office of Minority Health, CLAS standards, including the needs of individuals with disabilities
   d. Administer CHW training or ensure CHWs have training in:
      (1) Person-centered assessment
      (2) Outreach methods and strategies
      (3) Effective communication methods
      (4) Motivational interviewing
      (5) Health education for behavior change
      (6) Methods for supporting, advocating and coordinating care for individuals
      (7) Public health concepts and approaches
      (8) Community capacity building (i.e.; improving ability for communities to care for themselves)
      (9) Maintaining safety in the home
      (10) Basic behavioral health training to enable recognition of behavioral health needs

Execute and Monitor ICP

1. Hold regular Comprehensive Care Team meetings
2. Monitor Individual Progress on ICP. Establish:
   a. Key touch points for monitoring and readjusting the ICP
   b. Who will be involved in key touch points
   c. Standard Progress Notes
   d. Patient plan to meet self-directed care management goals
3. Modify process for health information exchange to accommodate the role and functions of the comprehensive care team. Establish:
   a. **What** data is shared
   b. **When** data is shared
   c. **How** referrals are facilitated
4. Establish a technology solution to alert comprehensive care team when a patient is admitted or discharged from an ED, hospital, or other acute care facility.
5. Establish a process for accessing an up-to-date resource directory (such as United Way 211), connecting individuals to needed community resources tracking referrals, and tracking barriers to care, and providing facilitation to address such barriers.

Assess individual readiness to transition to self-directed care maintenance

1. Assess individual readiness to self-manage and transition to routine primary care team support
2. Connect individual to ongoing community supports such as a peer support resource, as needed

Monitor individual need to reconnect with Comprehensive Care Team

1. Monitor and periodically re-assess transitioned individuals (ideally every 6-12 months)
2. Notify the comprehensive care team when the individual has a change of condition or circumstances that require a reconnection to the comprehensive care team

Evaluate and improve the intervention

1. Demonstrate comprehensive care team effectiveness through:
   a. Aggregate clinical outcome, individual care experience, and utilization measures that are relevant to the focus population's needs (i.e.; complex individuals)
   b. Improved performance on identified measures
2. Identify Quality Improvement Process
   a. Define process and outcome measures specific to the comprehensive care team intervention
   b. Develop training modules for the care team, community supports, and patients/families