CCIP Program Development

PTTF Meeting

March 17th, 2015

Agenda

- **Review and Confirmation of PTTF Draft Charge from HISC**
- **Review of CCIP Program Components and Approach**
- **Discussion of Membership Composition**
- **Discussion of Work Group Approach**
- **Confirmation of Next Steps**

Charge from the HISC

Charge from HISC

- **Practice Transformation Taskforce (PTTF) to redefine charge to include CCIP:**
  - Definition of technical support
  - Approach for direct funding
  - Approach and programmatic standards for CCIP
  - Prepare updated PTTF charge related to CCIP to Steering Committee for approval

Overview of CCIP Initial Design and Process

PTTF Charter Today (Excerpt)

This Task Force will develop for recommendation to the Healthcare Innovation Steering Committee, a proposal for the implementation of the Advanced Medical Home (AMH) model under the Connecticut Healthcare Innovation Plan (SHIP).

Modified PTTF Charter

This Task Force will develop for recommendation to the Healthcare Innovation Steering Committee, a proposal for the implementation of the Advanced Medical Home (AMH) model ***and the Clinical and Community Integration Plan*** under the Connecticut Healthcare Innovation Plan (SHIP).

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Overview of CCIP Initial Design and Process

Detailed below is the current "draft" approach to CCIP Program Development.

1. **Definition of CCIP**
2. **Approach to supporting CCIP Development**
3. **What assistance has proven effective?**
4. **With what organizations should these be developed?**
5. By What Approach?

Approach

- **Community integration** includes linkages with key long term support service partners (case management agencies and homemaker and companion providers), social services, health departments, schools, and essential community supports such as housing and food service providers
- **Clinical integration** includes integration with key clinical providers and development of internal and external capabilities to address health equity gaps, improve outcomes and effectiveness of care
- **Target populations:** All patient populations, especially individuals with complex healthcare needs and social determinant risks and vulnerabilities.
- **Target providers and community organizations:** CT FQHCs, Advanced Networks and community organizations
- **Desired CT outcome of programs** is to evolve primary care practice models to include capabilities that support community and clinical integration

Overview of CCIP Initial Design and Process

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Approach

- **Provide *a mix of technical support and direct funding* to Advanced Networks and FQHCs who participate in *Medicaid Quality Improvement and Shared Savings (MQISSP)* and community organizations** to build linkages with community resources and clinical care providers to better manage care and develop clinical integration capabilities:
  - "Advanced Networks" have developed physician networks and have the ability to develop community relationships
  - FQHCS
  - "Community Organizations" – to be defined
- Require joint application? and/or individual application?

Overview of CCIP Initial Design and Process

Capabilities	Examples of Capabilities
Oral health and behavior health integration	• Behavioral health is integrated into most Medicaid SSP programs; Dental included in fewer
Medication therapy management services	• CT experiment with pharmacists working closely with Medicaid patients in 2007, significant cost reductions – work informed CPCI initiative structure. Adopted as a national model
Dynamic clinical teams	• Hennepin Health (MN) – Serve Medicaid patients and saw positive shifts toward OP care; also part of CPCI initiative
E-consults between PCPs and specialists	• VA research – helpful to provide access to specialists where there are geographic or physical barriers
Community health workers as coaches and navigators	• Using MAs as health coaches to manage chronic disease • Health coaches to promote shared decision making
Closing health equity gaps	• Magnolia community initiative in LA focused efforts on closing disparities in community through addressing at all levels – individual, neighborhood and health system.
Improved care experience for vulnerable populations	• Little information available
Establishing community linkages with social services, LTSS and preventive health	• Physician support entities in Medicaid – can include convening stakeholders outside care setting
Identifying “super users” for care team interventions	• Helpful to identify to target prevalent preventable conditions (e.g.; obesity)
Enhancing PCP/staff skills in quality improvement methods and analytics	• Little information available
Producing actionable quality improvement reports	• Provision of performance reports, at different levels (i.e.; clinical and community), help improve health

Overview of CCIP Initial Design and Process

We have grouped these capabilities into three larger categories to facilitate planning and implementation.

1. Definition of CCIP
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Approach

Potential Categories of Grants/Support Activity:
Integration with other services:

- Integrating behavioral health and oral health
- Medication therapy management services
- Establishing community linkages:
  - Providers of social services
  - Long term supports and services (LTSS), and preventive health
  - Other community providers to target populations

Integration and Support of Providers across the Continuum:

- Building dynamic clinical teams
- Expanding e-consults
- Incorporating community health workers as health coaches and patient navigators
- Enhancing primary care provider/staff skills in quality improvement methods and analytics; and

Measuring and Reporting Functions to Support Desired CCIP outcomes:

- Closing health equity gaps
- Improving the care experience for vulnerable populations
- Identifying “super utilizers” for community care team interventions.
- Producing actionable quality improvement reports

Overview of CCIP Initial Design and Process

In addition, we are also reconsidering what the entirety of foundational elements for CCIP funding should include...

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Approach

- **Foundational elements related to CCIP funding for Advanced Networks:**
  - Demonstrated commitment to Medicaid as demonstrated by participation in MQISSP
  - Participation in MSSP program (and/or?)
  - Participation in commercial SSP contracts
  - Organized and sufficient physician network (to be defined)
  - Commitment to co-funding
  - Commitment to co-governance with local community organizations

Overview of CCIP Initial Design and Process

…as well as our approach.

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Approach

- **Competitive matching grants:**
  - Advanced Networks, FQHCS and community organizations, in combination or independently?
  - Technical support (to be defined)
  - Required participation in learning collaborative

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Key Questions

- What additional membership (and process) is required to ensure appropriate participation in the design and implementation of CCIP (e.g. community organizations?)

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Key Questions

- What design groups might we need?
  - Technical Support – definition of technical support content and approach?
  - Program design and standards?
  - Grant funding – purpose, targets, participants, construct of funding, criteria for selection (co-governance?), timing and process?
  - Learning collaborative – requirements for participation, focus of effort?

Next Steps

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Next Steps

- **PTTF to**:
  - Conduct interviews with other States to survey CCIP approaches
  - Obtain technical assistance from CMMI
  - Define high-level program design and standards
  - Test design and key components via survey and/or phone interviews
    - Core physician providers
    - Payers
    - Community representatives
    - Council participants
    - Program leaders from other states
  - Others?

Appendices

- Appendices

Overview of CCIP Initial Design and Process: Case Studies

Community and clinical integration is an area of innovation, but there are several examples in place today that may offer insight for us in our planning.

Michigan State SIM

Goal is to integrate with PCMHs through:

- ***Community integrated accountable systems***: vertically integrated networks that contract with PCMHs to facilitate cross-sector care management and health information exchange. Links will include those to community service systems and social and economic resources, including behavioral and public health resources.
- ***Community health innovation region***: will connect community integrated accountable systems to health-promoting community assets, bring community stakeholders together to set community priorities, address community health risk factors and raise "healthy living" capacity of community.
- ***Creating a statewide information exchange*** and performance reporting infrastructure – platform to exchange necessary health information between care setting and community health level.

Nemours Children's Health System

Focus is on transforming care for children, in particular for obesity:

- ***Multi-sector collaboration*** (schools, primary care and community based organizations)
- ***Policy changes*** – changed licensing standards for nutrition and activity requirements for child care establishments.
- ***Public information campaign*** – partnered with Delaware parks and rec to offer healthier options and park vending machines.
- ***Improvement in data systems*** to manage obese children.

Overview of CCIP Initial Design and Process: Case Studies

Magnolia Community Initiative

Focused on a high-risk community in downtown LA:

- ***Developed network of county agencies*** - public school district, PCMHs, head start and other social and economic support programs to improve community health.
- ***Worked as a single system*** to create conditions and behaviors that influence well-being across the life course.
- ***Partners work to align health related services and supports,*** this included:
    - Collaborative learning cycles to improve linkage protocols
    - Connecting life course science and practice
    - Providing care at multiple community levels (individual, neighborhood and health system)
    - Developing a Community Dashboard – displays population health outcomes, health behaviors and family and social conditions