Practice Transformation Task Force:

CCIP Development

May 19th, 2015

Meeting Agenda

Item	Allotted Time
1. Introductions	5 min
2. Public Comments	10 min
3. Minutes	5 min
4. Purpose of Today's Meeting	5 min
5. Orientation to Redesigned PTTF Website	5 min
6. Public Health Needs of Connecticut	20 min
7. Overview of Existing Community and Clinical Integration models	45 min
8. Discussion Questions and Key Takeaways	20 min
9. Next Steps	5 min

4. Purpose of Today's Meeting

1. Review of the health needs of Connecticut's residents

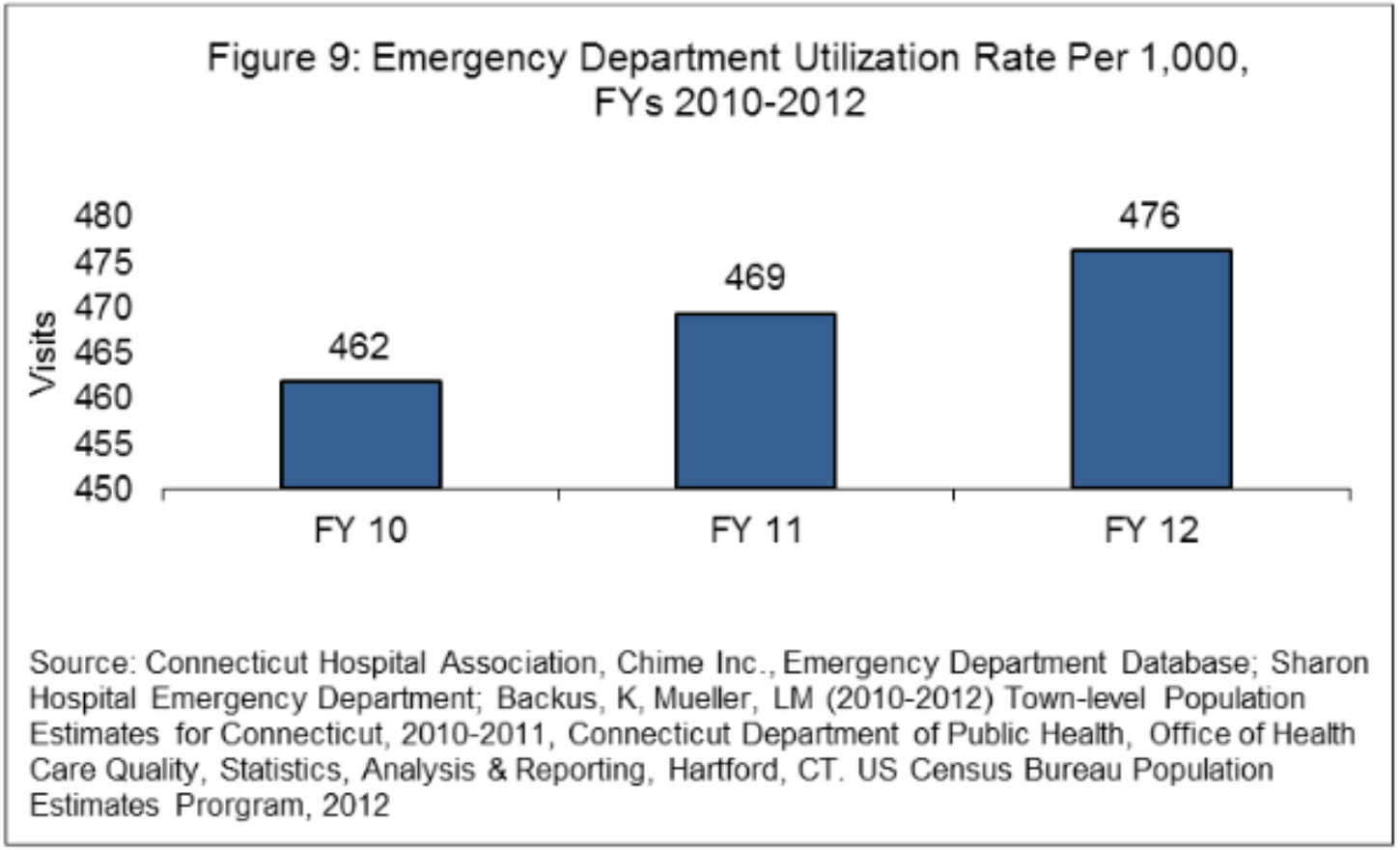
2. Agree upon CCIP working model that integrates the individual capabilities to improve health outcomes

3. Align current CCIP working model with best practices and the needs of Connecticut

5. Redesigned PTTF Website

6. Public Health Needs of Connecticut

Connecticut experiences one of the highest ED utilization rates in the country



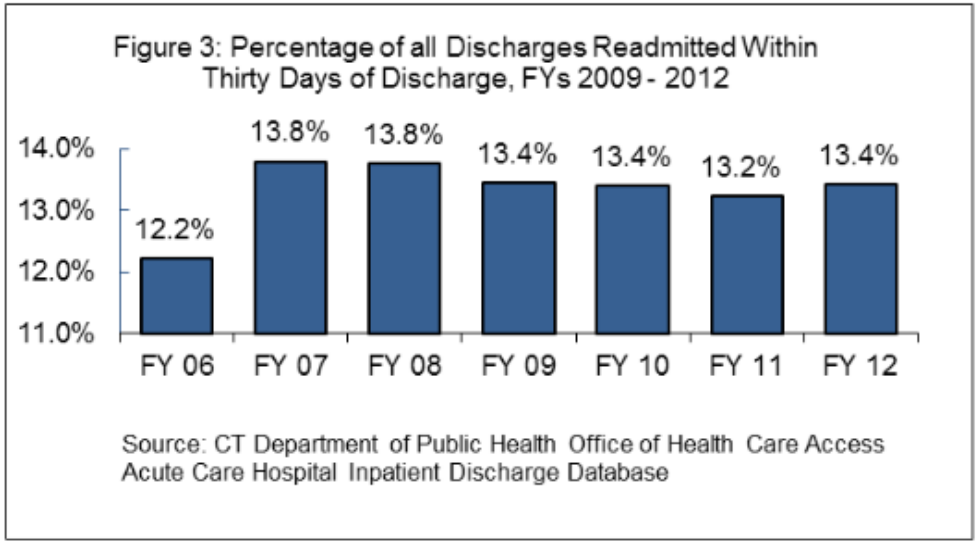
Potentially avoidable emergency department visits among Medicare beneficiaries, per 1,000 beneficiaries	2011	195	183	129	40

CT ranking out of 50 states

D.C. Radley, D. McCarthy, J.A. Lippa, S.L. Hayes, and C. Schoen, Results from a Scorecard on State Health System Performance, 2014, The Commonwealth Fu

6. Public Health Needs of Connecticut

Connecticut also experiences one of the highest readmission rates in the country and admissions for ambulatory sensitive conditions



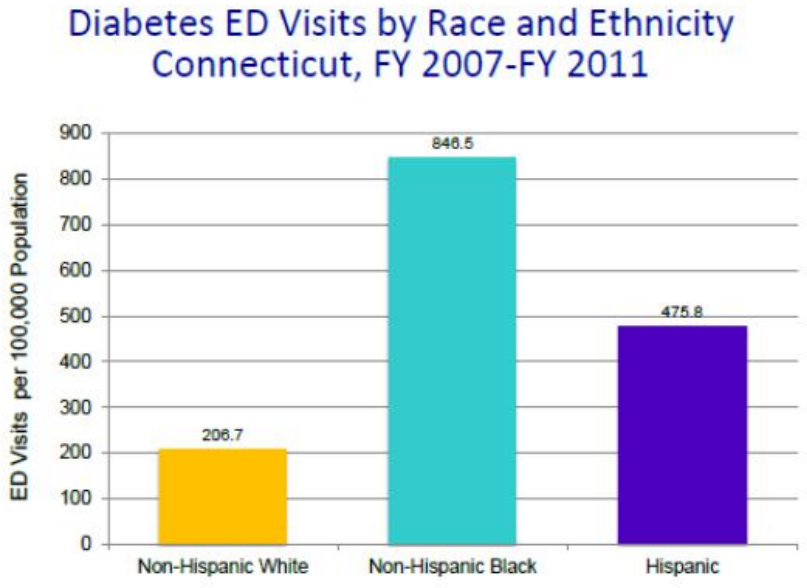
CT ranking out of 50 states

Avoidable Hospital Use

Hospital admissions among Medicare beneficiaries for ambulatory care–sensitive conditions, age 75 and older, per 1,000 beneficiaries	2012	75	68	41	39
Medicare 30-day hospital readmissions, rate per 1,000 beneficiaries	2012	52.0	45	26	36

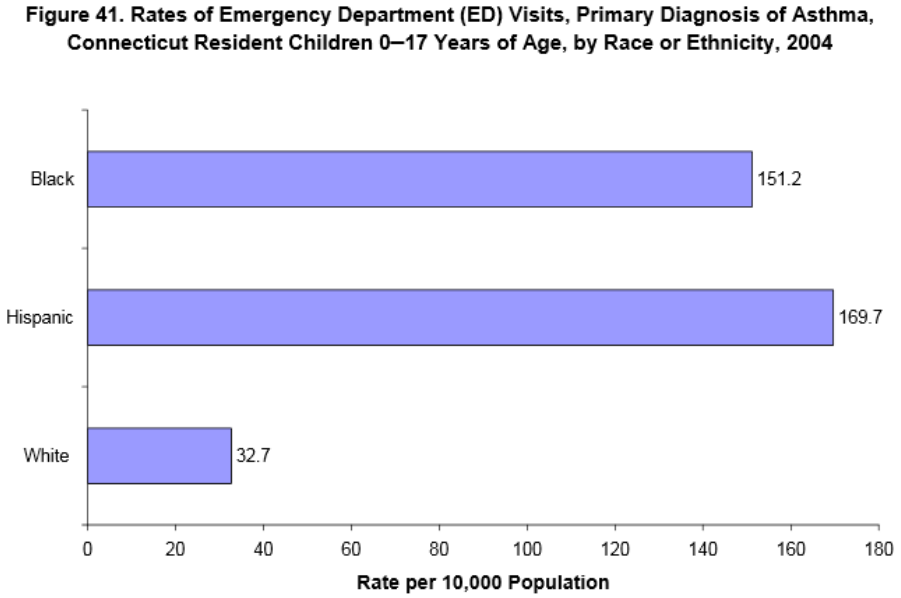
6. Public Health Needs of Connecticut

Emergency department use for diabetes and asthma vary greatly be race and ethnicity.



Source: Connecticut Department of Public Health, OCHA from *Connecticut Hospital Association CHIME, Inc. Emergency Department Database.*

Connecticut Department of Public Health
www.ct.gov/dph/SHIPcoalition

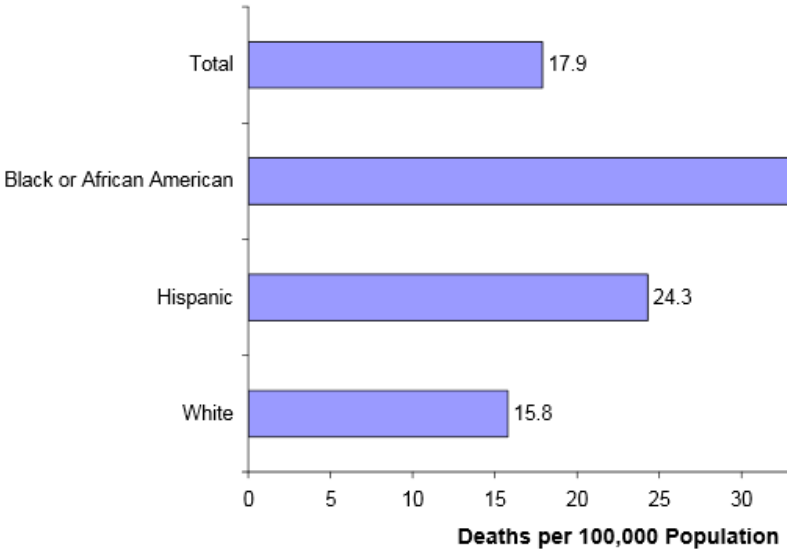


Source: Peng, Rodriguez, and Hewes 2008, 114; U.S. Census Bureau 2007b.

6. Public Health Needs of Connecticut

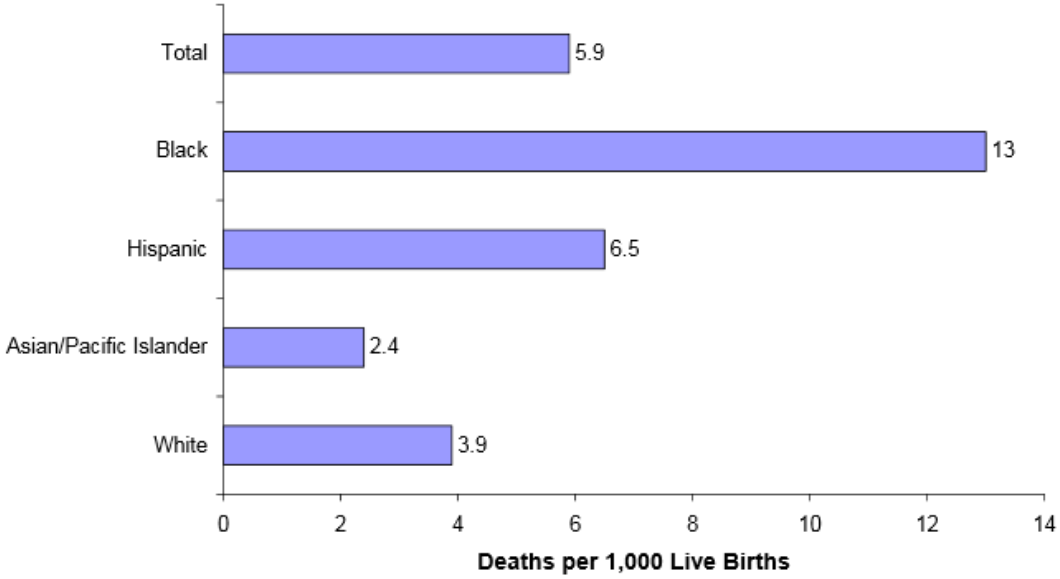
Diabetes mortality and infant mortality rates also vary by race and ethnicity.

Figure 7. Age-adjusted Death Rates for Diabetes, Connecticut by Race or Ethnicity, 2000–2004



Source: DPH 2008b. 2008v.

Figure 35. Infant Mortality Rate (IMR), Connecticut Residents, by Race or Ethnicity, 2001–2005

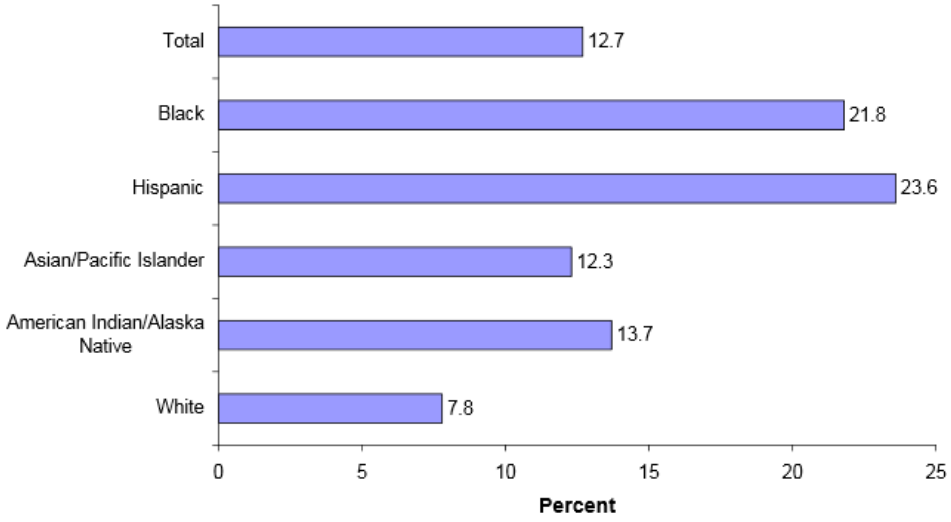


Source: DPH 2008j.

6. Public Health Needs of Connecticut

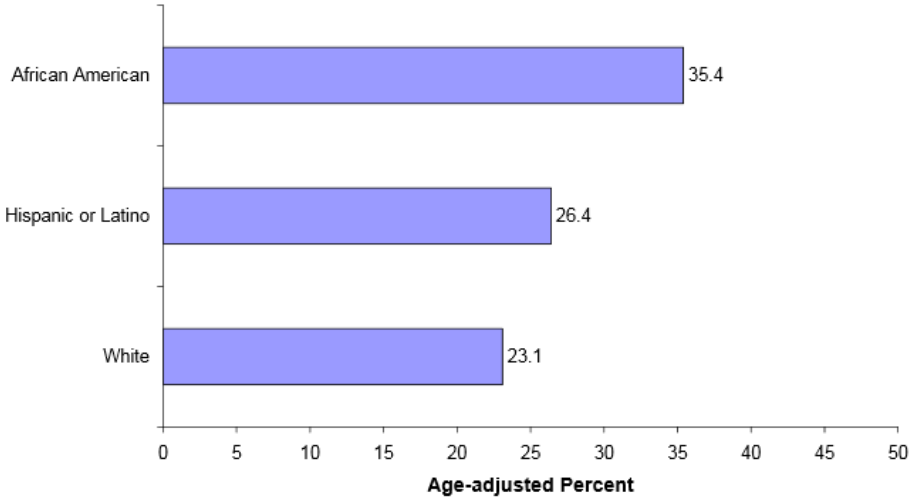
Many preventive care measures also vary by race and ethnicity.

Figure 36. Percent of Women Receiving Late or No Prenatal Care, Connecticut Residents, by Race or Ethnicity, 2002–2006



Source: DPH 2008k.

Figure 17. High Blood Pressure Awareness Rates, Connecticut Adults, by Race or Ethnicity, 2004–2005

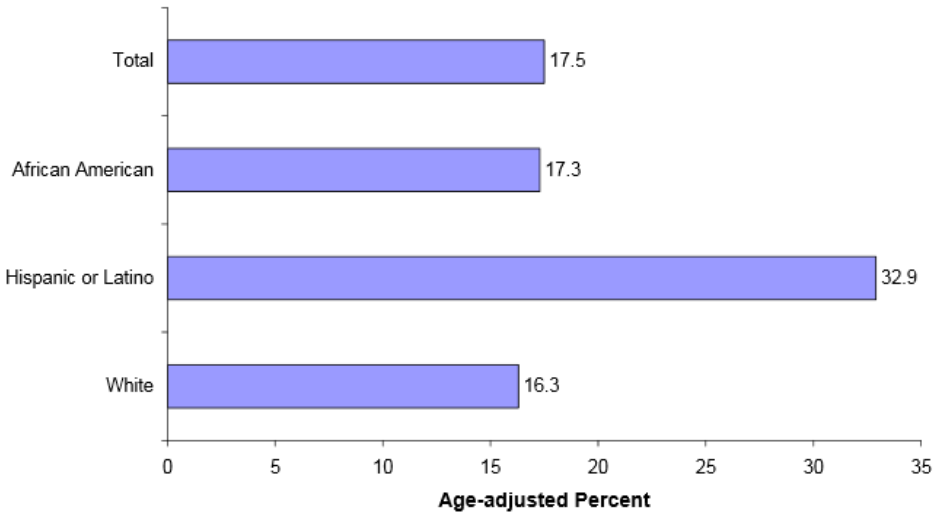


Source: DPH 2008a.

6. Public Health Needs of Connecticut

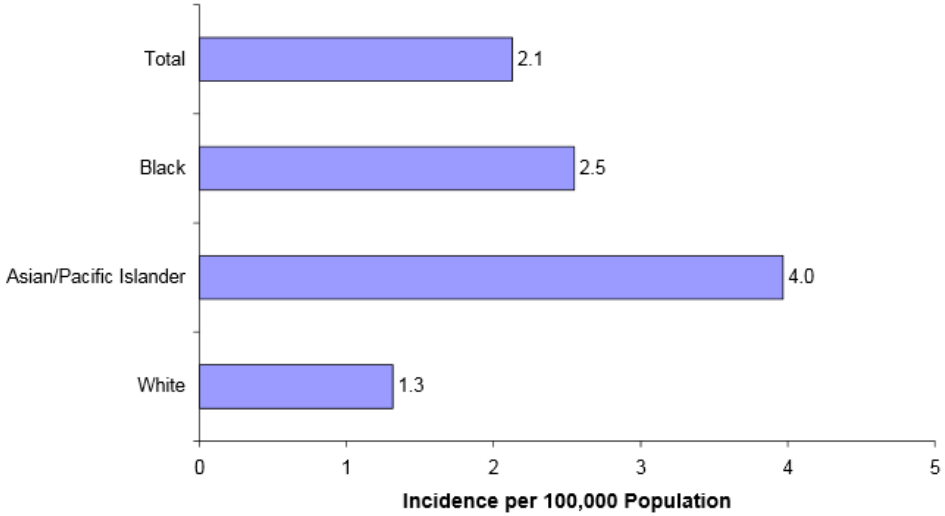
Many preventive care measures also vary by race and ethnicity.

Figure 18. Never Had Blood Cholesterol Checked, Connecticut Adults, Rates by Race or Ethnicity, 2005



Source: DPH 2008a.

Figure 27. Acute Hepatitis B Incidence Rates, Connecticut Residents, by Race, 2001–2005



Source: DPH 2008l, 2008y.

6. Public Health Needs of Connecticut

Health disparities devastate individuals, families and communities, and are *costly*:

- **From 2003-2006 there were $229.4 billion in direct medical costs from minority disparities**
  - **$57.35 billion/year**

- **30.6% of direct costs for African Americans, Asians & Hispanics were due to disparities**

- **The cost of the disparity for the Black population in Connecticut is between $550 million - $650 million a year**

Source: LaVeist, Gaskin & Richard (2009). The Economic Burden of Health Inequalities in the US. The Joint Center for Political & Economic Studies. As reported by DPH

7. Overview of Existing CCIP Models

Over the past couple weeks we have spoken to a number of subject matter experts nationally and locally who are knowledgeable about the design and execution of community and clinical integration models.

Interviewee(s)	Topic(s)	Status
Pat Baker & Elizabeth Kraus, Connecticut Health Foundation	• Measuring Health Equity Gaps • Community Health Workers	Complete
Bernadette Keleher	• Community Linkages	Complete
Bruce Gould and Petra Clark Dufner, UCONN Health/AHEC	• Community Health Workers	Complete
Camden Coalition	• Community Health Workers • Identification of complex patients	Complete
Terri DiPietro, Middlesex	• Identification of complex patients	Complete
Suzanne Lagarde, CEO Fair Haven Community Health Center	• E-consults • Community Health Workers	Complete
Steve Ruth, Systems and Management Consulting	• Care Transitions • Direct Messaging	Complete

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Interviewee(s)	Topic(s)	Status
Primary Care Coalition of Connecticut	• Identification of complex patients • Community Linkages • Care Transitions	Completed
Grace Damio, Hispanic Health Council, Director of Research and Training	• Community Health Workers	Completed
Dawn Lambert & Kate McEvoy, DSS	• Long Term Support Services • Money Follows Person • Dual Eligible Healthy Neighborhoods	Completed
Daren Anderson, Community Health Center, Inc.	• E-consults	Completed
Molly Gavin, CT Community Care, Inc.	• Long Term Support Services	Completed
Center for Healthcare Strategies	• Identification of complex patients • Identification of equity gaps • Dynamic Clinical Care Teams • Community Health Workers • Community Linkages	Completed
CT SIM State Program Experience (CMMI Support)	• All	Ongoing

7. Overview of Existing CCIP Models

What we have learned from the interviews and supplemental research is that there are three basic guiding principles to successful community and clinical integration.

Guiding Principles

1. **Model should be whole-person centered**
   - **Clinical and non-clinical support services should be brought to the patient**
   - **Care team structure should reflect the needs of the patient**
2. **Health information should be made available to all entities providing services to the patient (clinical and non-clinical)**
3. **Governance structure should hold all entities providing services to the patient accountable**

7. Overview of Existing CCIP Models

The research and interviews have confirmed that Connecticut's plan has all the right capabilities, but organizing and delivering these capabilities according to the guiding principles will be the key to successful execution of the CCIP.

Capabilities Stated in CCIP Model

Integration and Support of Providers Across the Continuum:

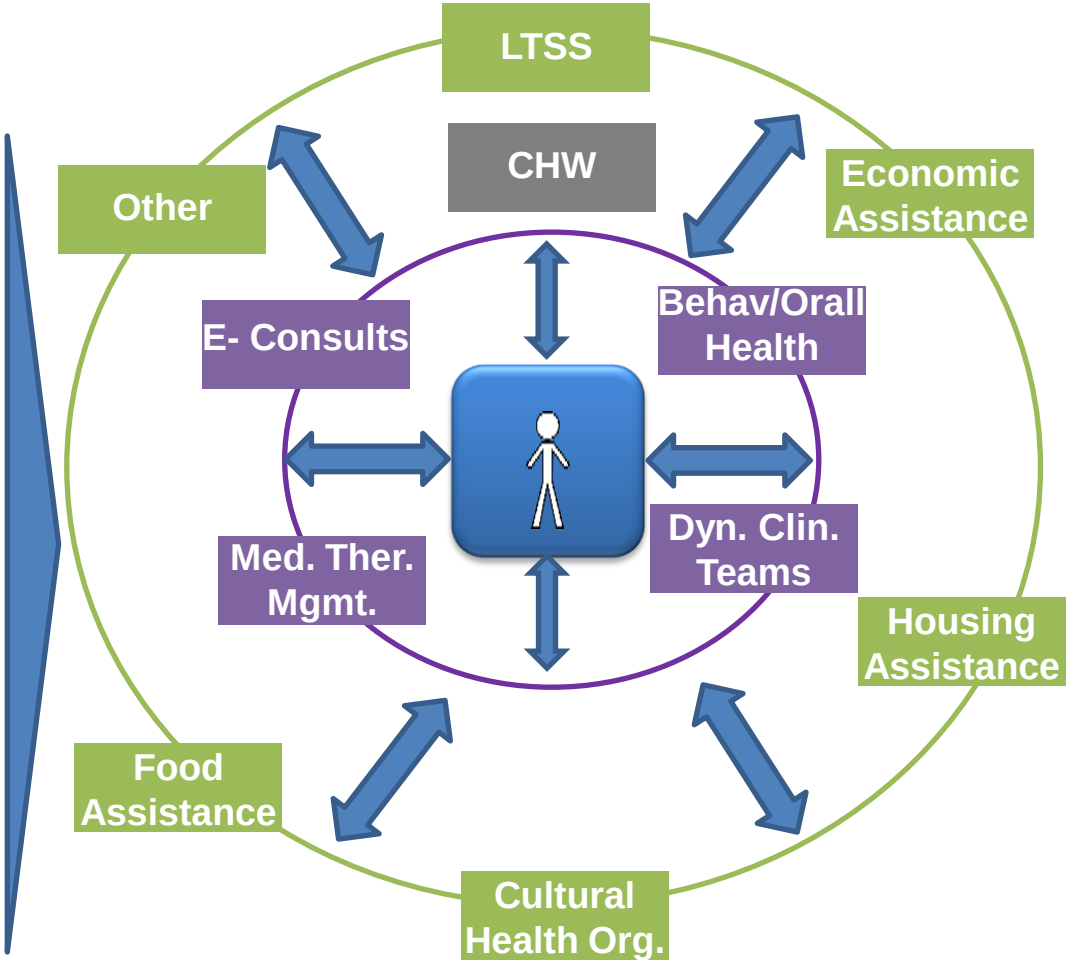
- Behavioral and Oral Heath
- Medication Therapy Management
- Dynamic Clinical Teams
- E-consults
- Community Health Workers

Integration with Other Services:

- Long Term Support Services
- Economic Assistance
- Housing Assistance
- Cultural Health Organizations
- Food Assistance

Measuring and Reporting Functions to Support CCIP Outcomes:

- Identification of complex patients in need of support
- Monitoring and improvement of equity gaps, care experience and quality

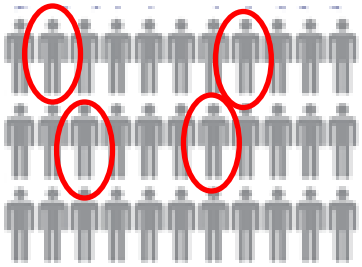


- Identification of complex patients in need of support
- Monitoring and improvement of equity gaps, care experience and quality

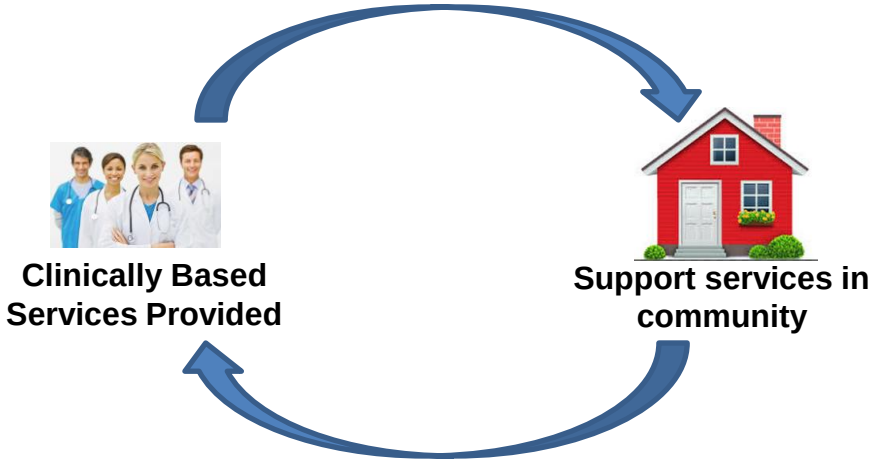
7. Overview of Existing CCIP Models

Review of existing models suggests that three key design questions need to be asked to ensure that the guiding principles are met.

I. ***What population will be targeted? What method will be used to identify patients?***



II. ***What mix of clinical and community support services will meet patient needs? Where should services be provided?***

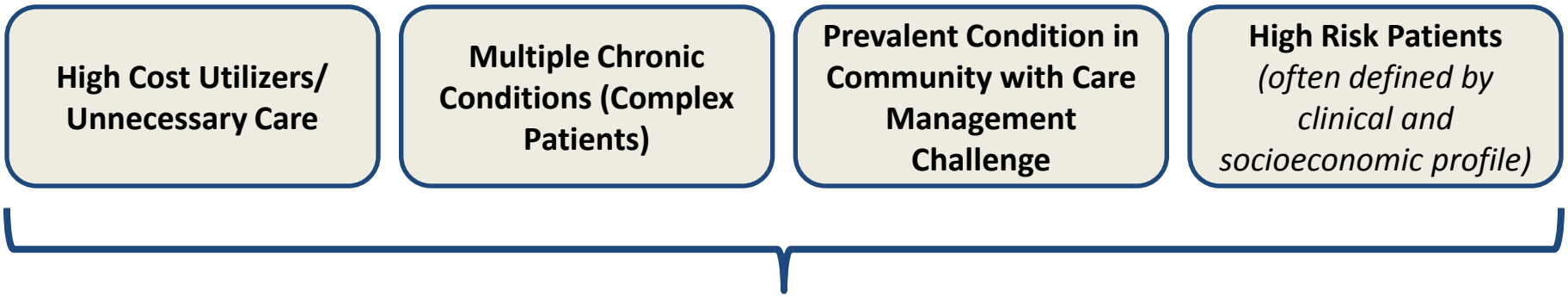


III. ***What governance and payment structure instill accountability across clinical and community partners?***

7. Overview of Existing CCIP Models

I. *What populations do existing models commonly target?*

Examples from existing models:

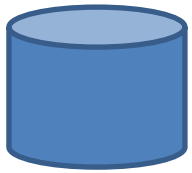


- Existing models often focus on patients who are considered to have complex needs and utilize the healthcare system frequently OR to support a particular care challenge in the community (e.g. address a health equity gap)
- The population targeted is usually informed by the needs of the community being served

7. Overview of Existing CCIP Models

I. *What methods do programs use to define the target population?*

A *Centralized Identification*

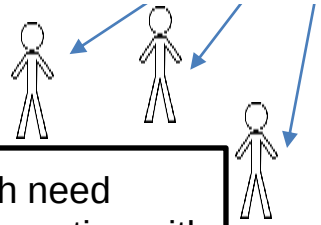


Centralized Data Source
(e.g.; Medicaid)

Algorithm Applied to Identify Target Population

Patient List:
- Smith
- Jones
- Johnson
- Etc.

Care Team Pro-actively Reaches Out to Patients



- ✚ Potential to capture high need patients infrequently interacting with care system
- ▬ Centralized source of data

VS.

B *Identification at Point of Service*

Hospital

ED

OP Setting (e.g.; FQHC, PCP)

Community Setting (e.g.; Soup Kitchen)

- Apply inclusion criteria when patient enters a clinical setting or accesses a community support service
- Often patient is initially flagged due to having frequent ED or IP hospital stays – triggers assessment for inclusion in program

- ✚ Capturing patient while engaged in receiving care/seeking out service
- ▬ May not capture the highest need patients

Most models also perform a readiness for change assessment to ensure the patient is ready to engage in a supportive care model

7. Overview of Existing CCIP Models

II.

What core capabilities are commonly provided through existing models?

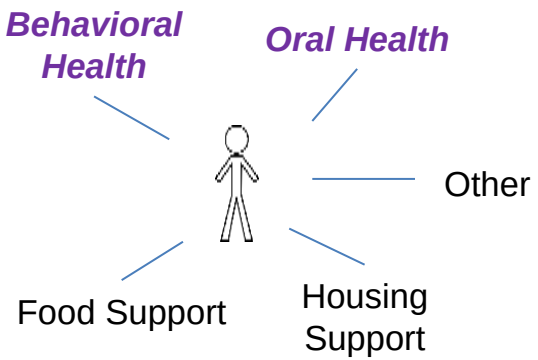
Multi-Disciplinary Care Team[1]

- Primary Care Physician or NP
- Social Workers
- RN
- ***Pharmacist***
- ***Behavioral Health Providers***
- ***Community Health Worker[2]***

Mix of providers varies

Key team member – role varies based on program, but often evaluates the social needs of the patient, identifies frequent/largest barriers to care, connects the patient to necessary/supportive services, and educates patient.

Established Linkages to Community



- Which services a patient is linked with depends on the patients needs, which is usually established by a risk/needs assessment conducted by a CHW
- Formal agreement between clinical providers and community services established that supports linkages

Color italicized resources are included in the CT CCIP vision

Note: [1] Dynamic Clinical Care Teams are referenced in the CCIP plan and is a slightly different concept than a multi-disciplinary team; [2] While part of the Care Team, the CHW plays a significant role and tends to function as a standalone program

7. Overview of Existing CCIP Models

II. ***What core <u>tools</u> are commonly used in existing models?***

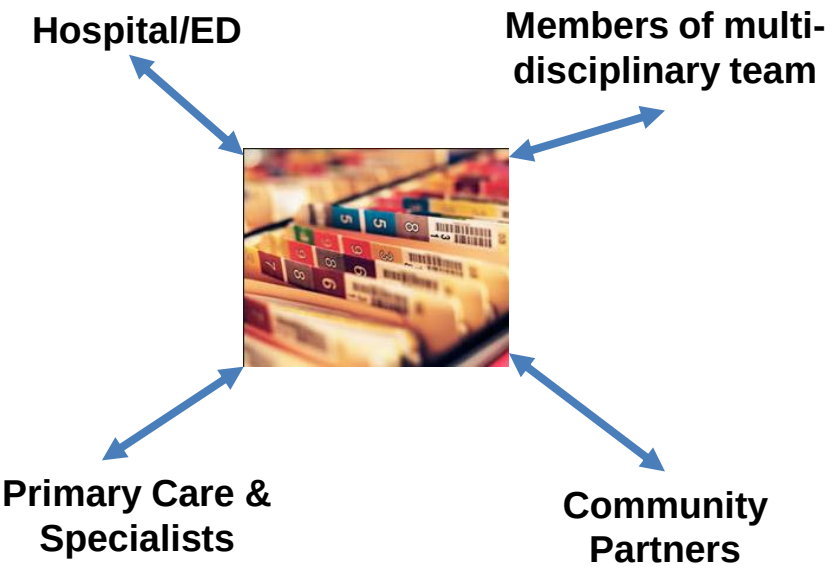
Risk/Needs Assessment

- What services does the patient need?
- What setting should services be provided?
- Which multi-disciplinary care team members are needed?

Hennepin

The Hennepin Care Model completes a <u>risk stratification</u> to place a patient in a well defined care track designed to meet the required level of care

Exchange of Health Information



Key support for ensuring all entities are aware of the patient care plan. This can be done through electronic (i.e.; HIE) or non-electronic means

7. Overview of Existing CCIP Models

II.

What core <u>enablers</u> are commonly used in existing programs?

Home Support/Care Transitions

Hospital

ED

Home

Longer-term Care Setting

<u>Transition Support Examples</u>

- Care transition coordinator
- Standardized hospital discharge protocol

- Provision of care management services in the home
- Longer-term home health care

7. Overview of Existing CCIP Models

III.

What are the common governance and payment structures that promote accountability?

- Coalition of providers (clinical and non-clinical) is created through formal agreements between providers within a given geography
- Coalition is governed by a board and by laws
- Uses data to understand patient utilization of the health system
- Some models utilize a global per member per month budget and provide reimbursement for non-clinical services (e.g.; community organization, community health workers, etc.)

The Camden Coalition Model provides a good example of what many states are doing

The Connecticut CCIP model will be created around an Advanced Network – design groups will have to consider how elements from the geographic/global models can inform accountability at the Advanced Network level

Camden Coalition of Healthcare Providers

7. Overview of Existing CCIP Models

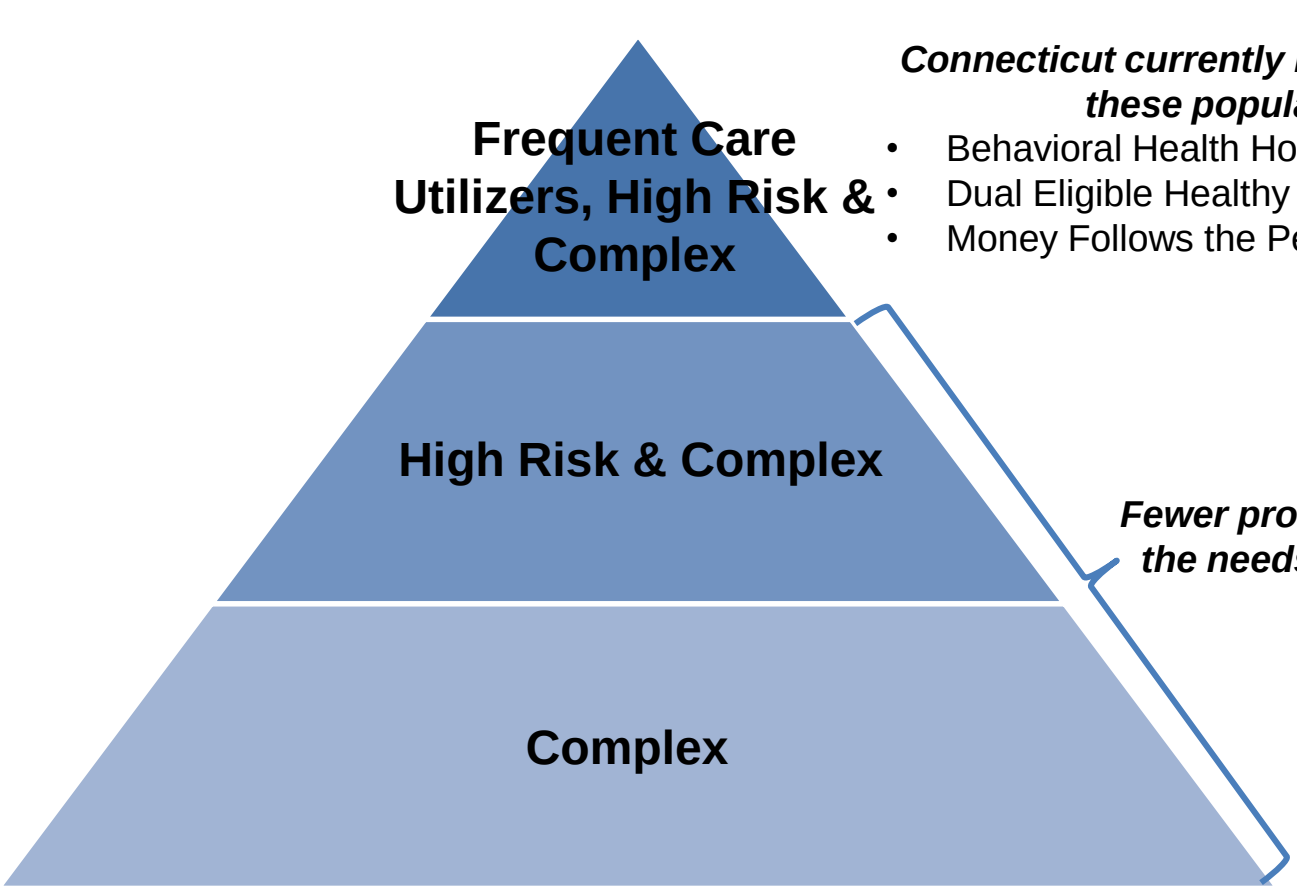
An inventory of all the capabilities prevalent in existing models reveals that Connecticut's CCIP model does not currently account for some crucial capabilities, but also goes beyond frequently provided capabilities.

Inventory of Capabilities	CCIP Model	Existing Models
Behavioral and Oral Health Integration	✓	✓
Medication Therapy Management	✓	
Multi-Disciplinary Team (aka Dynamic Clinical Teams)	✓	✓
E-Consults	✓	
Community Health Workers	✓	✓
Community Linkages (e.g.; LTSS, Housing, etc.)	✓	✓
Identification of complex patients who use the hospital frequently	✓	✓
Identification of patients experiencing health inequities	✓	✓
Identification of patients with poor care experiences	✓	
Exchange of Health Information		✓
Care Transitions		✓
Risk/Needs Assessment		✓
Provision of Care in the Home		✓

These additional CCIP capabilities should be added to the list for consideration by the design groups

8. Discussion Questions and Key Takeaways

Given the importance of tailoring a community and clinical integration program to the needs of the population being targeted, the most important question to answer is what is CCIP's target population?



Connecticut currently has programs for these populations:

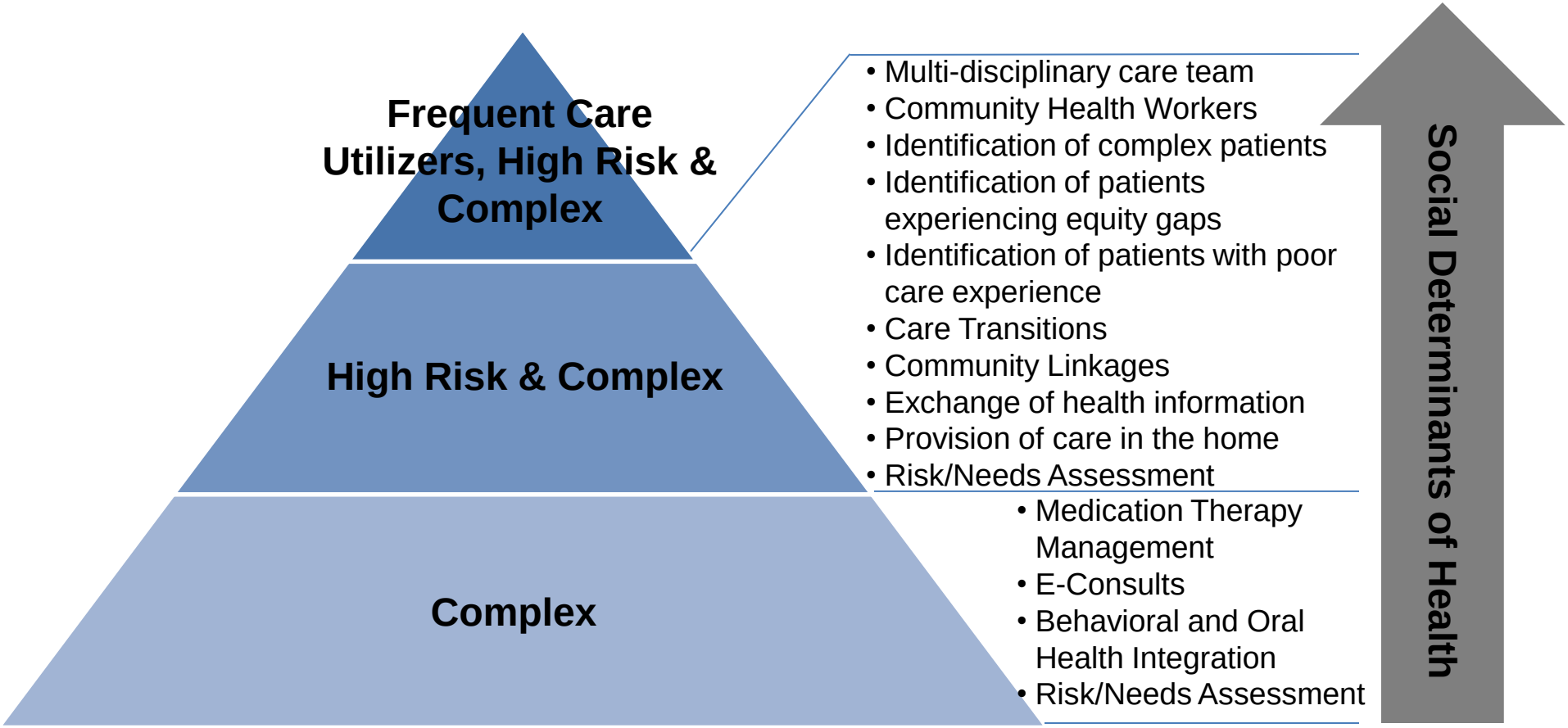
- Behavioral Health Homes
- Dual Eligible Healthy Neighborhoods
- Money Follows the Person

Fewer programs that address the needs of these patients

Social Determinants of Health

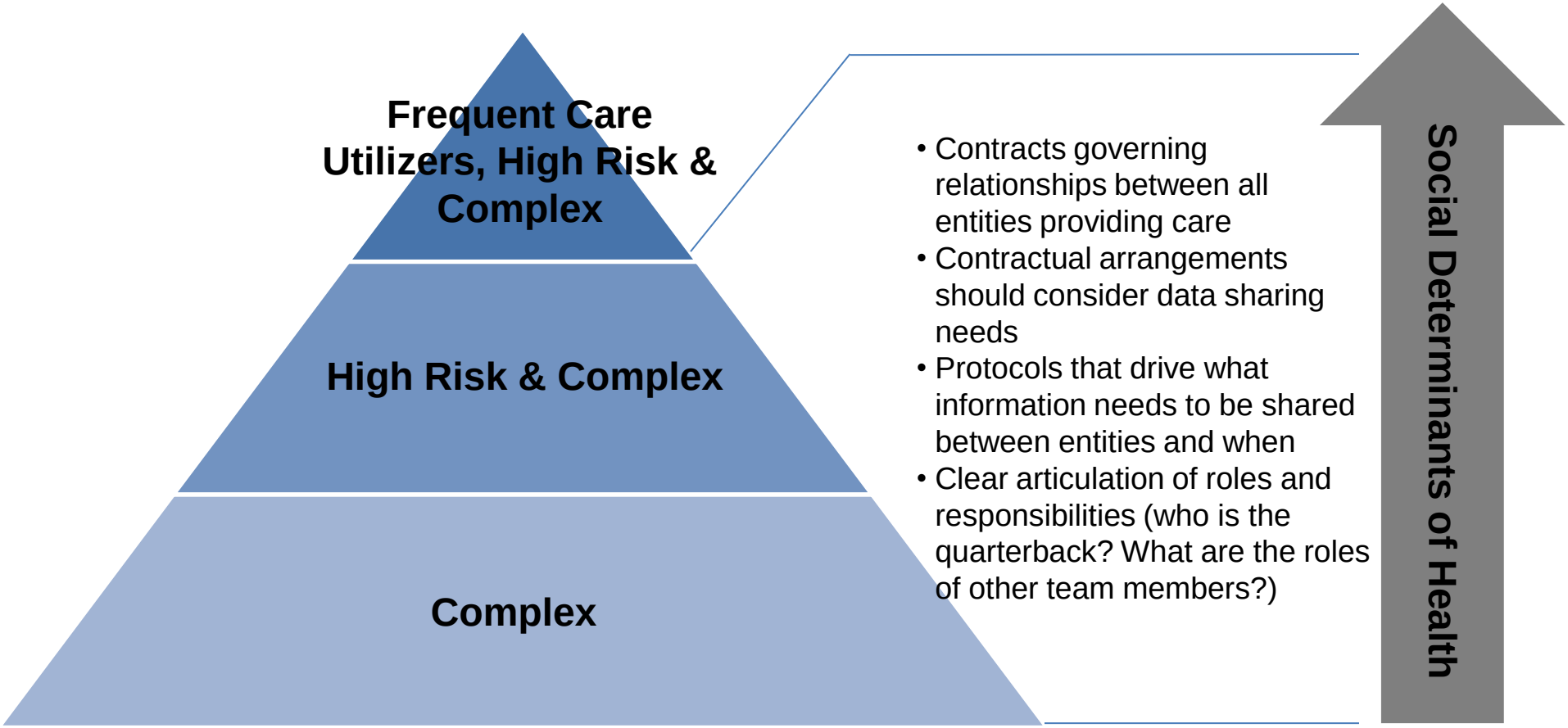
8. Discussion Questions and Key Takeaways

What programs will be required to serve the target populations? Is there anything missing?



8. Discussion Questions and Key Takeaways

How will the governance have to be adapted to ensure accountability for different populations?



Contracts will be required for all populations, but complexity will likely vary based on the complexity of the population

9. Next Steps

- Start design group sessions
- Continue subject matter expert interviews
- Share research and subject matter expert interview materials as it becomes relevant to design group work