Practice Transformation Task Force:

CCIP Development

June 9th, 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. CCIP Working Assumptions	15 min
6. CCIP Approach and Advanced Network and FQHC Participation	25 min
7. First Wave Design Group Review	50 min
8. Next Steps	5 min

4. Purpose of Today's Meeting

1. Gain agreement on CCIP working assumptions

2. Agree on how CCIP design will support meeting CT SIM goals and key CCIP success factors based on feedback from design groups

3. Gain understanding of key themes and conclusions surfaced during design groups

5. CCIP Working Assumptions

What is CCIP Intended to Accomplish?	Improve overall access to high quality clinical care for complex patients (either due to clinical reasons, social reasons or both), patients experiencing a gap in their care, and improve overall care experience for the general patient population through improving clinical and community integration
What is the role of PTTF?	Design a program that will address the needs of complex patients, patients experiencing health equity gaps, and patients with poor care experiences that identifies and integrates needed clinical and community services
Who will implement CCIP initiatives?	Advanced Networks and Federally Qualified Health Centers (FQHCs)
How does CCIP Implementation fit into CT SIM?	Advanced Networks and FQHCs participating in the Medicaid Quality Improvement Shared Savings Program (MQISSP) will be eligible for technical assistance and/or matching grant funds to build CCIP capabilities
Which patients will participate in CCIP programs?	Any patients seeking care at an Advanced Network or FQHC that is participating in CCIP and would benefit from the additional services
What is the incentive for Advanced Networks and FQHCs to participate?	Manner for Advanced Networks and FQHCs to receive support (through technical assistance or matching grant funding) to build capabilities that will help them be successful in MQISSP and other shared savings programs
How will CCIP promote population health?	CCIP will act as a stepping stone toward building the types of clinical and community relationships that support improving health at the population level, serving as a building block for health enhancement communities (HECs)

5. CCIP Working Assumptions

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

- Improve Population Health
- Promote Consumer Engagement
- Reduce Health Inequities
- Lower Costs
- Improve access, quality and patient experience

Connecticut will achieve this through seven strategic initiatives:

Pop Health Mgmt.	MQISSP	AMH Glide Path	CCIP	Quality Alignment	VBID	Consumer Engagement

CCIP Objective:

Improve overall access to high quality clinical care for complex patients (either due to clinical reasons, social reasons or both), patients experiencing a gap in their care, and improve overall care experience for the general patient population through improving clinical and community integration

- Reduce Health Inequities
- Improve access, quality, and patient experience
- Lower costs
- Long-term: improve population health

5. CCIP Working Assumptions

Improving outcomes for patients through CCIP will improve performance across a range of metrics, many of which will be part of the aligned quality scorecard.

Goals	Related Metrics
Population Health	• Plan being completed in short-term • Quality dashboard measures in long-term
Health Equity	• ***Health Equity Design Group Measures*** • Recommendation is to stratify quality measures by race, ethnicity, language and disability data to identify inequities
Access	• Advanced Medical Home performance against standards • Includes: care experience measures (e.g.; ease of getting an appt.), various means of access (e.g.; after hours, phone and patient portal access)
Quality	• Emerging quality scorecard • Provisional Measures: preventive, acute & chronic conditions, behavioral health, obstetrics • Measures Under Review: ***care experience***, care coordination, patient safety, ***readmissions, ambulatory sensitive condition admissions, ED measures***
Cost	• Overall PMPM
Care Experience	• ***PCMH Consumer Assessment of Healthcare Providers and Systems (CAHPS) endorsed by the NQF***
Consumer Engagement	• Formal plan and metrics yet to be developed

6. CCIP Approach & AN/FQHC Participation

With each design group we tested some assumptions about the overall approach for CCIP regarding key success factors:

What was proposed…

- Successful CCIP implementation will require accountability between community and clinical partners (i.e.; formal community linkages)
- Measuring and reporting capabilities will help to
  1) Inform the needs of the population to define a target population and strategies to address their needs
  2) Monitor and evaluate progress toward CT SIM goals and adjust practices to better meet evolving needs
- Allowing freedom of AN/FQHC to defined their own target population

What was heard…

- **Concerns about the lack of standardization**
  1) If ANs/FQHCs are given too much flexibility to define their own population
  2) Challenges to standardizing all aspects of the CCIP program such as communication between clinical and community partners to promote accountability
- **Overly burdensome requirements without clear financial incentives will deter participation**
  1) Governance expectations
  2) Monitoring/reporting expectations

6. CCIP Approach and AN & FQHC Participation

CCIP

CCIP Objective:

Improve overall access to high quality clinical care for complex patients (either due to clinical reasons, social reasons or both), patients experiencing a gap in their care, and improve overall care experience for the general patient population through improving clinical and community integration

As a reminder, the review of existing programs intended to meet similar objectives suggests there are three guiding principles that should govern program design:

1. **Model should be whole-person centered and include clinical and community components**
   - **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 for providing the agreed upon services and patient outcomes**

How can the CCIP meet its objectives, follow the guiding principles, and take into consideration the PTTF's concerns?

6. CCIP Approach and AN & FQHC Participation

1

We suggest the CCIP design should strive for standardization while also allowing some flexibility for Advanced Networks and FQHCs to implement a program that best suits their population's needs in order to ensure **whole-person centeredness**

We propose that Advanced Networks and FQHCs have the freedom to choose the population they want to focus on, but the CCIP will broadly define three population types. This will promote:

- *A standardized CCIP approach across Advanced Networks and FQHCS*
- *Addressing known needs of Connecticut patients*
- *Alignment with overall CCIP and CT SIM goals*

The target populations could be:

- Reduce readmissions and ASC admissions, ED use

Complex Patients (clinically and socially)

- Reduce health equity gaps

Populations Experiencing Equity Gaps

- PCMH CAHPS
- BH access
- BH screening/ depression remission

Behavioral Health

Within each of these population subsets, ANs and FQHCs will define a target population

6. CCIP Approach and AN & FQHC Participation

The impact of seamlessly **sharing health information** between clinical and community partners will be a key success factor. Will information sharing be more seamless if CCIP designs three core interventions that specifically outline needed clinical capabilities and clinical and community linkages?

***Proposed* Interventions:**

Complex Patients (clinically and socially)

Multi-Disciplinary Team ✚ *CHW as Patient Navigator*

Community and Clinical Linkages (to be defined)

Populations Experiencing Equity Gaps

CHW as Health Coach ✚ *Community and Clinical Linkages (to be defined)*

Behavioral Health

Behavioral Health Integration
(screening, integrated BH care or referral to BH provider, confirm linkage to provider, follow-up)

Standardized interventions for each population will allow for:

- Defining an objective of each capability and relationship
- Standards that govern those capabilities and relationships (i.e.; approach to a care plan approach, clear definitions of roles and responsibilities
- Standards for communication – how, when, and by whom

Note: These capabilities in these combinations align with Design Group One's prioritization and synergies

6. CCIP Approach and AN & FQHC Participation

CCIP initiatives will promote broader Advanced Network and FQHC success with shared savings, potentially incentivizing networks to instill a governance structure to promote accountability and ensure high performance.

Quality Scorecard

Complex Patients (clinically and socially)

Multi-Disciplinary Team + *CHW as Patient Navigator*

Community and Clinical Linkages (to be defined)

- Reduce readmissions
- Reduce ambulatory sensitive condition admissions

Populations Experiencing Equity Gaps

CHW as Health Coach + *Community and Clinical Linkages (to be defined)*

- Health Equity Design Group metrics

Behavioral Health

Behavioral Health Integration (ID, integrated BH care or referral to BH provider, confirm linkage to provider, follow-up)

- PCMH CAHPS BH access measures
- BH screening/depression remission

We propose that CCIP will promote accountability through making recommendations on a governance structure that includes community partners and oversees CCIP specific and broader quality performance.

6. CCIP Approach and AN & FQHC Participation

The clinical capabilities not directly pointed out in the CCIP approach outlined, will still be discussed and recommendations will be developed, but they will be viewed as elective capabilities that the AN or FQHC can implement beyond the core capabilities.

Core

Complex Patients (clinically and socially)

Multi-Disciplinary Team ✚ *CHW as Patient Navigator*

Community and Clinical Linkages (to be defined)

Quality Scorecard

- Reduce readmissions
- Reduce ambulatory sensitive condition admissions

Populations Experiencing Equity Gaps

CHW as Health Coach ✚ *Community and Clinical Linkages (to be defined)*

- Health Equity Design Group metrics

Behavioral Health

Behavioral Health Integration (ID, integrated BH care or referral to BH provider, confirm linkage to provider, follow-up)

- PCMH CAHPS BH access measures
- BH screening/ depression remission

Elective

Care Experience *Medication Therapy Management* *E-Consult* *Oral Health* *Care Transitions*

7. Design Group Report Outs

As a reminder the design groups are being tasked with providing input to create recommendations to the HISC on what the CCIP should look like.

As was shared with the PTTF at the April 28th meeting the recommendations developed for each capability would contain the elements below:

Content CCIP Will Develop:

- **Overview of Research:** Narrative summarizing existing best practices and models that were drawn upon to inform the design group's decisions on CCIP capability design.
- **Capability Objective:** Summary of the purpose of the capability, what it will accomplish, and how it ties to the goals of the CCIP initiatives.
- **Capability Standards:** Required capability standards for Advanced Networks/FQHCs receiving technical assistance or matching grant funding.
- **Capability Approach:** Options for implementing the capability based on the defined standards.
- **Capability Metrics:** Process and outcome metrics to track success of capability implementation and desired objectives.

- The content on the left will be developed with input from design group members and key stakeholders
- This work will provide an initial point of view on what the design components should be for each community and clinical integration capability
- The PTTF's work will be submitted to the HISC for consideration and serve as a starting point for the CCIP to be tested and further defined with experience.

7. Design Group 1: Clinical Capabilities

Design Group 1 considered all of the clinical capabilities and prioritized them using the following criteria:

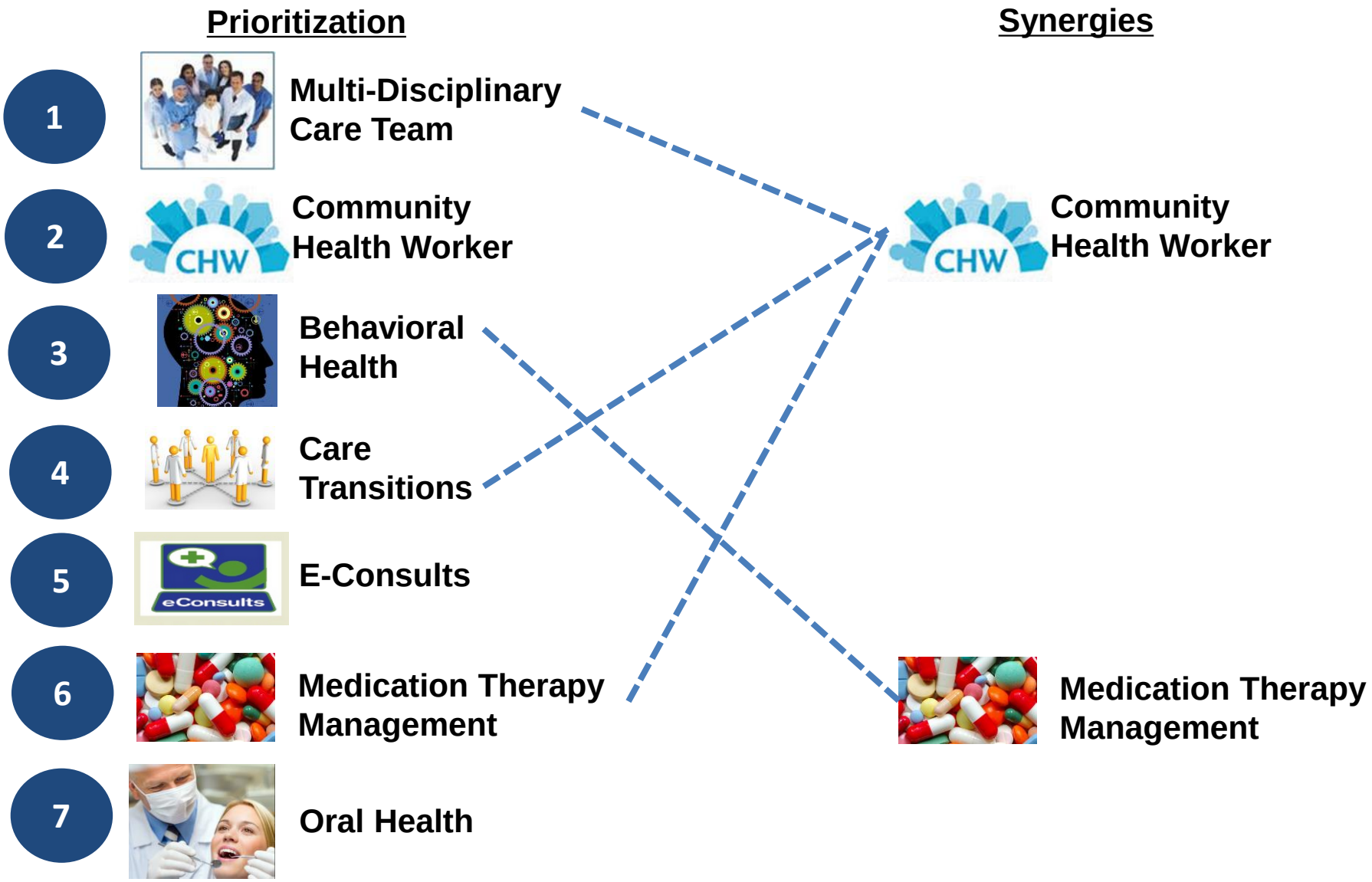
1. Evaluate how each capability could contribute to achievement of the SIM goals, based on demonstrated results from industry experience

2. Assess where CCIP capabilities are complementary to existing programs and where they are redundant to existing programs (within SIM and CT more broadly)

3. Determine if there are synergies between capabilities that when implemented together will have an enhanced impact

7. Design Group 1: Clinical Capabilities

The clinical capabilities were prioritized and paired as follows:



Note: Lower prioritized items will still have standards developed, but will be focused on later in the process

7. Design Group 1: Clinical Capabilities

Group 1 Discussion Questions:

1. Reactions to the prioritization and synergies? Agreement? Additional thoughts?

2. How can the work of the behavioral health design group be incorporated into the CCIP work?

3. Comfortable considering redundant and/or complementary aspects of capabilities as we go? DSS will do a webinar in the next several weeks for the PTTF to learn more about existing programs.

7. Design Group 2: Community Capabilities

This design group considered the following in their conversation about incorporating community services with clinical services.

1. Identification of the needed community resources/relationships
2. Clearly defined roles and responsibilities for all involved entities
3. Formal agreement that holds all entities accountable for providing agreed upon services

7. Design Group 2: Community Capabilities

Design group two felt that if the program is designed around a target population, the needed community linkages could be infinite.

Potential Community Linkages

Behavioral Health & Substance Abuse

Courts

Hispanic Health Council

Cultural Organizations

School Based

Nutrition/Food Security

Housing

Economic Assistance

LTSS[1]

Transportation

If the target population definition is more prescriptive, should a discrete set of linkages be chosen so the way they are implemented across Advanced Networks/FQHCs is standardized?

Notes: 1) Long term support include home-maker, personal care assistance, companion, and home health.

7. Design Group 2: Community Capabilities

Accountability between the clinical and community providers participating in CCIP initiatives will be crucial.

Proposed Required Elements:	**Consensus:**
• Clearly identified goals of partnership	
• Agreement of roles and responsibilities of all involved members	
• Governance structure (i.e.; oversight)	*Further Discussion Needed*
• Agreement structure	*Further Discussion Needed*

7. Design Group 2: Community Capabilities

Continued discussion is needed on how prescriptive recommendations should be on the governance structure and agreement type between clinical and community entities.

Governance Structure and Agreement Structure Can Range from Informal to Formal:

Informal **Governance** *Formal*

Taskforce ***Formal Board with Bylaws*** ***Joint Oversight By One Member from Each Entity***

Regardless of formality of governance, those involved in oversight should be responsible for ensuring both parties are performing agree upon tasks and monitoring performance and addressing performance issues when they arise

Agreement

Handshake

MOU

Contractual Arrangement

The group discussed a minimum requirement, but freedom to choose formality beyond that

7. Design Group 2: Community Capabilities

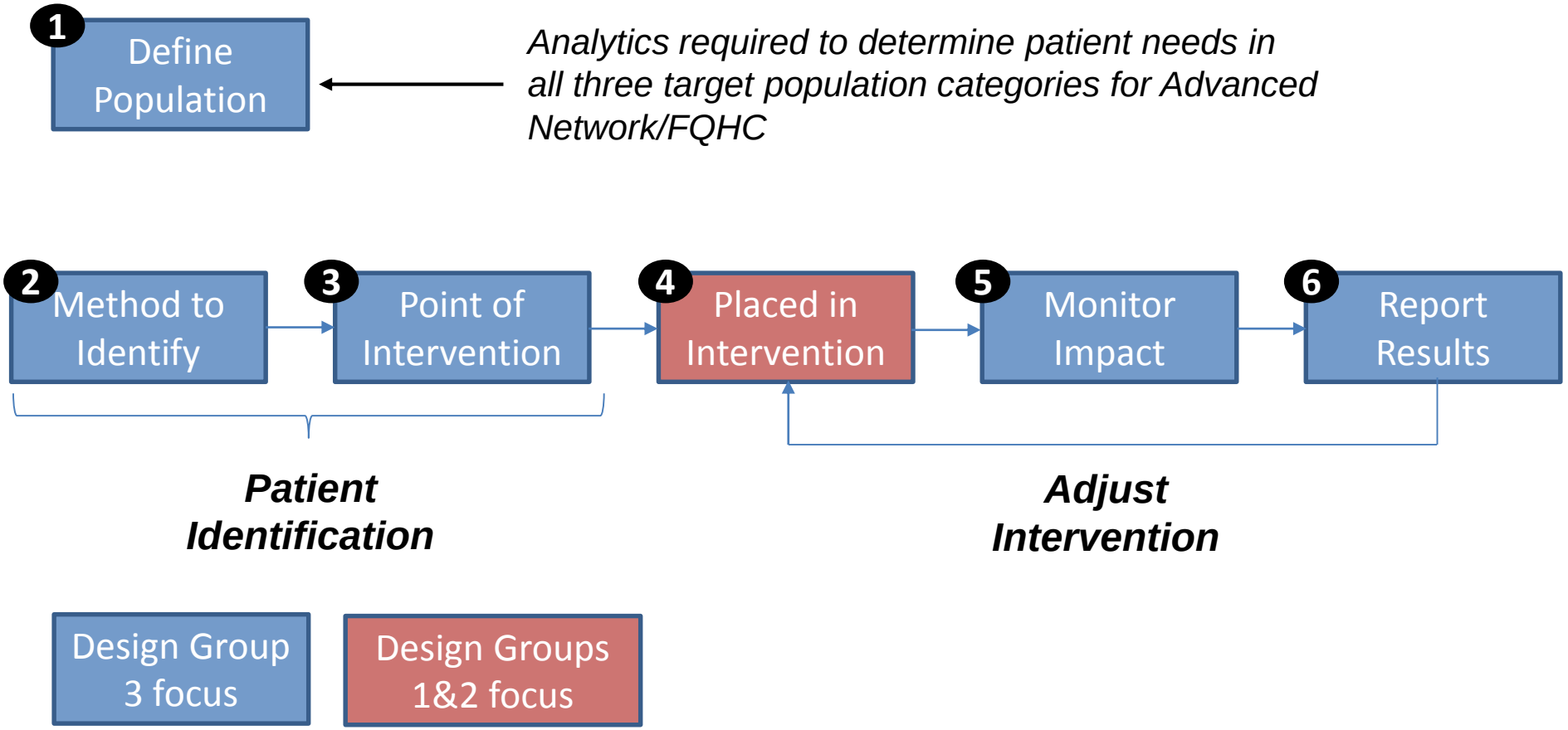
Group 2 Discussion Questions:

1. How prescriptive should recommendations be around government and agreement structure?

2. Should the governance structure be to oversee CCIP more broadly not just the community relationships?

7. Design Group 3: Measuring & Reporting

This design group discussed guidelines for defining the target population, a process to identify patients for intervention, and monitoring and reporting on the performance of the intervention.



7. Design Group 3: Measuring & Reporting

1 Define Population

Design group three voiced that there should be some amount of standardization in the way target populations are defined.

Providing the options to define the target populations within each category would align with broader CT SIM goals:

The target populations could be:

- Reduce readmissions and ASC admissions, ED use

Complex Patients (clinically and socially)

- Reduce health equity gaps

Populations Experiencing Equity Gaps

- PCMH CAPS BH access
- BH screening/ depression remission

Behavioral Health

What supporting evidence should be provided?

- **<u>Use standardized data source?</u>** Any community data source or should it be consistent across ANs/FQHCs? Examples: local public health, hospital assessment, health system utilization, etc.
- **<u>Should analysis to determine the population focus in each category be done in a standardized manner?</u>**
- **<u>Should justification of need be demonstrated?</u>** What should the AN/FQHC have to provide to justify why they chose the CCIP they are pursuing
- **<u>Should community input be required?</u>** This will help understand consumer perspective of needs (*suggested by design group two*)

7. Design Group 3: Measuring & Reporting

2 Method to Identify

3 Point of Intervention

What guidelines should govern the process for identifying the target population?

What method will be used to identify the patient?

Examples from other models…

- Technology infrastructure to flag potentially eligible patients
  - # of admits to ED or Hospital over defined period of time
  - Pro-active identification through centralized data source; list shared with community entities that can intervene
  - All patients screened when seen in primary care setting
- Point of intervention
  - Hospital, ED, OP setting, community setting, centralized data source
- Develop specific inclusion/exclusion criteria
  - Should there be a minimum requirement for inclusion (e.g.; readiness assessment)?
- Define data sharing requirements and associated implications (e.g.; EHR platform, direct messaging, etc.)

Discussion Questions:

- How prescriptive does the PTTF want to be around recommending a process to identify patients for CCIP? Should there be a standardized approach for each population type (e.g.; complex, equity gap, behavioral health?)
- Should flexibility be allowed to account for varying levels of technical infrastructure different ANs and FQHCs have?

7. Design Group 3: Measuring & Reporting

5 Monitor Impact

6 Report Results

To promote accountability the CCIP should have the capability to measure and report on the performance of the clinical capabilities and community linkages pursued.

CCIP Performance Dashboard/Scorecard

What?	CCIP specific performance metrics (process and outcome)
Why?	Promotes transparency, accountability, and performance improvement
Who?	Individual or committee responsible for reviewing on a pre-determined and consistent basis
Result?	Improvement opportunities identified and addressed

Discussion Questions:

- Who should be responsible for monitoring performance? Addressing barriers?
- How perscriptive should the guidelines be?

8. Next Steps

- Schedule additional Design Group 1 Session
- Develop straw-man standards and implementation approaches for design groups to react to prior to second set of design sessions
- Hold DSS webinar on CT programs that could influence/impact CCIP work (date TBD)