Practice Transformation Task Force:

CCIP Development

June 30th, 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. Conflict of Interest	20 min
6. Target Populations Defined	15 min
7. CCIP Overall Approach	20 min
8. CCIP Target Population Interventions	25 min
9. Remaining CCIP Design Needs	10 min
10. Next Steps	5 min

4. Purpose of Today's Meeting

1. Gain understanding of target population definitions

2. Come to consensus on CCIP overall program structure

3. Achieve understanding of CCIP interventions for each target population

4. Gain understanding of remaining CCIP design needs to be addressed by design groups and offline with subject matter experts

5. Conflict of Interest

See document distributed via email on 6/22

6. Target Populations Defined

Target Population	Definition
 **Complex Patients (clinically and socially)**	Patients who have either multiple complex medical conditions, multiple social determinants of health, or a combination of both that impact their overall health and healthcare management
 **Populations Experiencing Equity Gaps**	A specific subset of patients who are experiencing a disparity demonstrated through a difference in treatment patterns and/or health outcomes. More detail on the following pages on how to define the subset (i.e.; how narrowly defined it should be) and for which disease states/treatments
 **Behavioral Health**	Defined as any patient with a mild to moderate behavioral health disorder including mental health, substance abuse, or history of trauma

6. Target Populations Defined: Complex Patients

Complex Patients (clinically and socially)

Many of the CCIP like models reviewed to date focus on complex patient populations defined as patients with complex clinical and social needs. Integrating community support into clinical care is of particular importance in these interventions to address the social determinants of heath.

Camden Coalition of Healthcare Providers

"The Coalition's Care Management and Care Transition Programs were designed to target high cost, complex patients for improved care transitions and care coordination…. Our staff has segmented this patient population into two groups: those who have no source of primary care and typically have significant social and mental health issues; and those with more stable primary care and less severe social issues" [1]

Hennepin

"The population is…characterized by an identified lack of social support and scant history of health insurance. As a group, they are heavy users of expensive acute care services and are overrepresented among the 5 percent of Medicaid beneficiaries who drive more than 50 percent of spending nation-wide."[2]

Notes: [1] http://www.camdenhealth.org/programs/care-management-program/; [2] www.Hennepin.us/healthcare

6. Target Populations Defined: Equity Gaps

Populations Experiencing Equity Gaps

Defining equity gaps more narrowly may help to align the CCIP intervention better with broader CT SIM goals and will provide focus for Advanced Networks/FQHCs to design interventions to reduce equity gaps.

	Suggested Focus[1]:	**Rationale:**
Clinical areas of focus?	• Diabetes • Asthma • Hypertension • LDL Screening • Colorectal Screening	• All will be tracked on aligned quality scorecard • Areas where there are known disparities in CT
Focus on a pre-determined subset of the population?	• African American populations • Latino populations	• Health equity scorecard measures may be limited to African American and Latino populations • Statistically will allow for large enough base rates to reliably assess performance • Known disparities among these two race/ethnicity groups in CT

Discussion Question:

Should technical assistance be limited to ANs/FQHCs that focus on equity gaps aligned with the populations tracked on the scorecard **or** should ANs/FQHCs have the freedom to choose any population (e.g.; Asian populations)?

Notes: [1] Health Equity Design Group (HEDG) recommendations will be finalized on 7/29

6. Target Populations Defined: Behavioral Health

Behavioral Health

The focus of CCIP will be to address mild to moderate behavioral health disorders as opposed to severe and persistent mental illness (SPMI) as the Medicaid behavioral health homes are intended to address the needs of patients with SPMI needs.

2013 OHA Report[1] on Access to Mental Health and Substance Abuse Services in Connecticut found….

1. CT lacks an overall vision of how to ***recognize, evaluate and provide services*** for individuals with mental health and substance use delivery services

2. CT's current ***delivery system*** for mental health and substance use services is ***fragmented and inconsistent***

3. Mental health and substance use services are ***largely unknown*** and ***not targeted broadly*** enough

4. Mental health and substance use care largely is ***not integrated into overall healthcare models*** nor is it designed to improve outcomes and reduce racial and ethnic disparities

Designing a behavioral health focused CCIP intervention will address a number of the identified needs in Connecticut:

- Process for consistent behavioral health screening
- Process to connect patients to behavioral health services when a need is identified through integration of primary care and behavioral health services
- Support broader awareness among Advanced Networks and FQHCs of available behavioral health services in the community
- Accountability for making connections for behavioral health through measuring and reporting on CCIP intervention

Notes: [1] http://www.ct.gov/oha/lib/oha/report_of_findings_and_recs_on_oha_hearing_1-2-13.pdf

7. CCIP Overall Approach

Before the PTTF can start to design the CCIP program in more depth, two key decisions on the approach are required.

Required Decisions	Consensus?
1. How will the target populations be defined? • *Agreement on three broadly defined target populations* • *Will determine at end of process if ANs/FQHCs have to implement the CCIP program across all three target populations*	
2. How will the interventions around the target populations be defined?	To Be Discussed

7. CCIP Overall Approach

While there was agreement in our last meeting on the core clinical interventions for each target population, more discussion is needed on defining the approach for core community linkages for each target population.

Core

Complex Patients (clinically and socially)

Multi-Disciplinary Team ✚ *CHW*

Community and ***Clinical Linkages (to be defined)***

Populations Experiencing Equity Gaps

CHW ✚ ***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)

Quality Scorecard

- Reduce readmissions
- Reduce ambulatory sensitive condition admissions
- Health Equity Design Group metrics
- PCMH CAHPS BH access measures
- BH screening/ depression remission

Elective

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

7. CCIP Overall Approach

Allowing the ANs/FQHCs to identify their own set of community linkages will ensure that linkages are developed that meet the needs of the target population, but may not support identification of a clear value proposition for the community partner.

We propose a balanced approach that allows for flexibility and specificity:

Proactive Identification:

Specifying community linkages upfront will allow for more clarity on the ***value proposition*** for community partners and inform formality of governance and agreement

Flexibility:

Allows for community linkages to be more tailored to the needs of the ANs/FQHCs target populations and promotes involvement of community partners in solving to those needs

Potential Approaches That Will Promote/Achieve Balance:

High

1. Identify set of 5 community linkages and request that the Advanced Networks/FQHCs develop 2 out of 5 linkages

2. Identify 2-3 common community linkages but allow Advanced Networks/FQHCs to propose alternative linkages as they see fit

3. Allow Advanced Networks/FQHCs to pick community linkages that meet their population' s needs

Level Prescriptiveness

Low

Recommended Approach

8. CCIP Target Population: Complex Patients

Core

		Quality Scorecard
 **Complex Patients (clinically and socially)**	**Multi-Disciplinary Team ✚ CHW** **Community and Clinical Linkages**	• Reduce readmissions • Reduce ambulatory sensitive condition admissions
 **Populations Experiencing Equity Gaps**	**CHW ✚ Community and Clinical Linkages**	• Health Equity Design Group metrics
 **Behavioral Health**	**Behavioral Health Integration (screening, 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*

8. CCIP Target Population: Complex Patients

Existing models designed to address complex populations have developed a multi-disciplinary care team that specifies a point person for clinical care management and another to facilitate social needs.

Most Common MDT Members
NP/PCP *(clinical management)*
RN *(care manager/navigator)*
Social Worker *(available for consultation)*
Community Health Worker *(social determinants of health management)*

Note: Camden Coalition and Hennepin use similar models.

The Hennepin model has demonstrated success building a program around this MDT structure

- Increase in primary care visits
- Decrease in ED visits and IP admissions
- Improved percentage of patients receiving optimal diabetes, vascular and asthma care
- Improved patient satisfaction

Key collective responsibility of MDT is to conduct a needs assessment of the patient in order to create a care plan that addresses their clinical, behavioral, and social needs

The MDT is a core component of the Hennepin model, the design of which is rooted in the recognition that what drives health care utilization and outcomes happens outside the clinical setting

Notes: http://www.camdenhealth.org/programs/care-management-program/; www.Hennepin.us/healthcare

8. CCIP Target Population: Complex Patients

The community health worker plays a central role on the MDT for complex patients, working directly with the patient to address their social needs and acting as the representative of those needs in the clinical setting.

Example of Success…

Bronx Lebanon Hospital Center Community Health Worker Program Case Study

- **CHWs integrated into primary care team:**
  - Acts as member of care team to support care management in particular around social issues
  - Built relationships with community based providers
- **CHWs Responsible for:**
  - Conducting intake assessments
  - Contributing to development of care plan and supports tailoring of plan to address barriers
  - Care coordination support to help with navigating the health system
  - Linking patient to needed social services
- **CHW Management/Oversight:**
  - Structured communication between community based CHWs and care team
- **Demonstrated Success:**
  - Improvement in medical conditions

Notes: http://www.chwnetwork.org/media/122708/making-the-connection-chw-health-homes-sept-2012.pdf; Integrated into primary care does not necessarily mean the CHWs work in the clinical setting, but are part of the clinical multidisciplinary team

8. CCIP Target Population: Complex Patients

To optimize the success of the MDT there should be clearly defined roles for each member, structured communication, and clear care objectives identified for each patient.

Multidisciplinary Team

Physician/NP

RN (Care Manager/ Navigator)

Social Worker

Community Health Worker

The CCIP Recommendations Will Require Defining:

- Roles & responsibilities of each member of the MDT members
- Guidelines for shared care plan development and execution
- Guidelines for information sharing around progress on care plan (in person, electronically, etc.)
- Communication frequency and forum to discuss barriers to successful execution of care plan and identify solutions
- Training requirements for MDT members if necessary (e.g.; CHW)
- Infrastructure needed to support process (e.g.; data sharing, protocols, etc.)

8. CCIP Target Population: Complex Patients

While all complex patient populations will likely have a slightly different community support needs, commonly formed community linkages in other CCIP like models include:

Frequent Community Linkages

Housing

Home Health

Vocational/Employment

LTSS[1]

Economic Assistance

Legal

Transportation

Food Security

Discussion Question:

Which 2-3 do you think are most relevant for the PTTF to develop recommendations for?

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

8. CCIP Target Population: Equity Gaps

Core

Elective

Complex Patients (clinically and socially)

Multi-Disciplinary Team ✚ **CHW**

Community and Clinical Linkages

Populations Experiencing Equity Gaps

CHW ✚ **Community and Clinical Linkages**

Behavioral Health

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

Quality Scorecard

- Reduce readmissions
- Reduce ambulatory sensitive condition admissions

- Health Equity Design Group metrics

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

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

8. CCIP Target Population: Equity Gaps

Often equity gaps in care arise from language barriers and challenges with the cultural competency of providers and cultural gaps in patient education, in particular for patients with chronic illnesses that often have a lifestyle component as part of the treatment.

Community Health Worker

Community Health Workers have demonstrated the ability to improve health outcomes for patients experiencing disparities in their current care through providing culturally competent/relevant education in the community setting and connecting patients to needed community/social resources.

Examples of Success:

Program Focus	CHW Intervention	Results
Improve breast feeding for low-income Latina women	• CHWs were mothers who had successfully breastfed for > 6 months • Trained by lactation consultants for 40 hours over two weeks • 3 pre-natal home visits; Daily perinatal visits; 9 post-partum home visits	• Longer exclusive breast-feeding • Fewer diarrheal episodes • Mothers remained amenorrheic longer
Care management disparities for type 2 diabetes care for Latino populations	• CHWs were both Latina with clinical backgrounds (bilingual/bicultural) • 65 hours of training on diabetes care and required lifestyle changes + 25 hours of training on motivational interviewing and communication skills • Process identified to integrate CHW into primary care • 17 home visits	• Sustained improvements in HbA1c • Long-term sustained fasting glucose levels

8. CCIP Target Population: Equity Gaps

In creating the CCIP recommendations, the design group will have to consider how the roles and responsibilities of the community health worker tasked with addressing health equity gaps will differ from the community health worker working with complex patients.

Diabetes

Asthma

Hypertension

CHW Role To Address Health Equity Gaps

- **Consistent with CHW for Complex Patients**
  - Address social needs of patient outside the clinical setting
  - Act as representative of those needs within the clinical setting
  - Contribute to development and execution of care plan
- **Manner in which CHW role differs for Health Equity Gaps**
  - Training/education of CHW will be disease state specific
  - Necessary community linkages will be different, requiring a different knowledge base of available community support services and relationships with those services

8. CCIP Target Population: Equity Gaps

The community linkages that will support closing equity gaps will likely be those that support culturally sensitive patient education or disease specific support (e.g.; nutrition support for diabetes).

Frequent Community Linkages

Cultural Organizations

Economic Assistance

Nutrition

Housing/ Living Environment

Discussion Questions:

1. ***Which 2-3 do you think are most relevant for the PTTF to develop recommendations for?***
2. ***Should one linkage be developed for each clinical area with an equity gap (i.e.; diabetes, asthma, HTN, etc.)?***

8. CCIP Target Population: Behavioral Health

Core

Elective

Complex Patients (clinically and socially)

Multi-Disciplinary Team ✚ **CHW**

Community and Clinical Linkages

Populations Experiencing Equity Gaps

CHW ✚ **Community and Clinical Linkages**

Behavioral Health

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

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

8. CCIP Target Population: Behavioral Health

The focus on the CCIP behavioral health intervention will be to promote more consistent screening, referrals, and linkages to behavioral health for mild to moderate behavioral health disorders through improved primary care and behavioral health integration.

CCIP Design Needs:

- Process for consistent screening (becomes part of routine primary care practice)
- Structure/agreement between primary care and behavioral health partners that:
  - Supports successful referral/connection
  - Allows for follow-up with primary care on outcomes and ongoing management needs
- Process/guidelines for referrals (likely informed by structure/agreement)

Design Considerations:

- Focus screening efforts on specific behavioral health need?
  - *Depression, substance abuse, trauma?*
- Range of integration options to consider from coordinated to co-located to fully integrated[1]
  - *Consider feasibility of options from structural and financial standpoint*
  - *Level of integration will impact formality of governance structure and agreement type between partners and influence value proposition*

Notes: [1] See appendix for detailed integration options

9. Remaining CCIP Design Needs

With the overall CCIP approach identified, the following areas of CCIP design are remaining and will be addressed in more detail by the design groups and offline with subject matter experts.

Design Group 1

- Develop standards for all core and elective clinical capabilities

Design Group 2

- Develop standards for all core and elective community capabilities and requirements for relationships (i.e.; governance structure, agreement type, roles and responsibilities)
- Identify/define the value proposition for community partners (will likely inform type of governance structure/agreement needed)

Design Group 3

- Identify analytic capabilities and approach for Advanced Networks/FQHCs to define their target populations within the broader target population definitions
- Define approach to identify target populations in practice
- Define requirements for measuring and reporting capabilities (i.e.; how will performance be monitored, by whom, and how will accountability be instilled)

10. Next Steps

- Review revised timeline:

WORKSTREAM/ACTIVITY	June					July				August					September			
	1	8	15	22	29	6	13	20	27	3	10	17	24	31	7	14	21	28
Practice Transformation Taskforce (CCIP)																		
Practice Transformation Taskforce Meetings (*Note: italics are newly proposed meetings)*		9			30				28					1				29
Practice Transformation Taskforce Executive Team Meetings	2			23				21					25				22	
Design Group 1							17											
Design Group 2										6								
Design Group 3												20						

- Plan to work offline with SMEs throughout process to have more in depth conversations with the design groups after developing straw-man recommendations in each area with key SMEs

- Hold Design Group 1 on July 17th prior to July 28th PTTF meeting

- Focus of July 28th meeting will be on community linkages and clinical capability standards (in a more finalized format to share what DG 1 has developed and surface any key questions DG1 wants input on)

Appendix

Primary Care – Behavioral Health Integration Options

COORDINATED Key Element: Communication		CO-LOCATED Key Element: Physical Proximity		INTEGRATED Key Element: Practice Change	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice
Behavioral health, primary care, and other health care providers work:					
In separate facilities, where they:	In separate facilities, where they:	In same facility not necessarily same offices, where they:	In same space within the same facility, where they:	In same space within the same facility (some shared space), where they:	In same space within the same facility, sharing all practice space, where they:
• Have separate systems • Communicate about cases only rarely and under compelling circumstances • Communicate, driven by provider need • May never meet in person • Have limited understanding of each other's roles	• Have separate systems • Communicate periodically about shared patients • Communicate, driven by specific patient issues • May meet as part of a larger community • Appreciate each other's roles as resources	• Have separate systems • Communicate regularly about share patients, by phone or e-mail • Collaborate, driven by need for each other's services and more reliable referral • Meet occasionally to discuss cases due to close proximity • Feel part of a larger yet ill-defined team	• Share some systems, like scheduling or medical records • Communicate in person as needed • Collaborate, driven by need for consultation and coordinated plans for difficult patients • Have regular face-to-face interactions about some patients • Have a basic understanding of roles and culture	• Actively seek system solutions together or develop work-arounds • Communicate frequently in person • Collaborate, driven by desire to be a member of the care team • Have regular team meetings to discuss overall patient care and specific patient issues • Have an in-depth understanding of roles and culture	• Have resolved most or all system issues • Communicate consistently at the system, team, and individual levels • Collaborate, driven by shared concept of team care • Have formal and informal meetings to support integrated model of care • Have roles and cultures that blur or blend