Practice Transformation Task Force:

CCIP Development

July 28th, 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. Progress to Date and Next Steps	15 min
6. Program Design: Complex Patients & Patients with Equity Gaps	60 min
7. Vermont Case Study	15 min
8. Next Steps	5 min

4. Purpose of Today's Meeting

1. Provide update on progress to date and approach to next steps

2. Obtain feedback and input on design approach and standards for CCIP interventions – complex patients and patients with equity gaps

3. Share summary of Vermont's experience and identify lessons for Connecticut

5. CCIP and Context of SIM

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

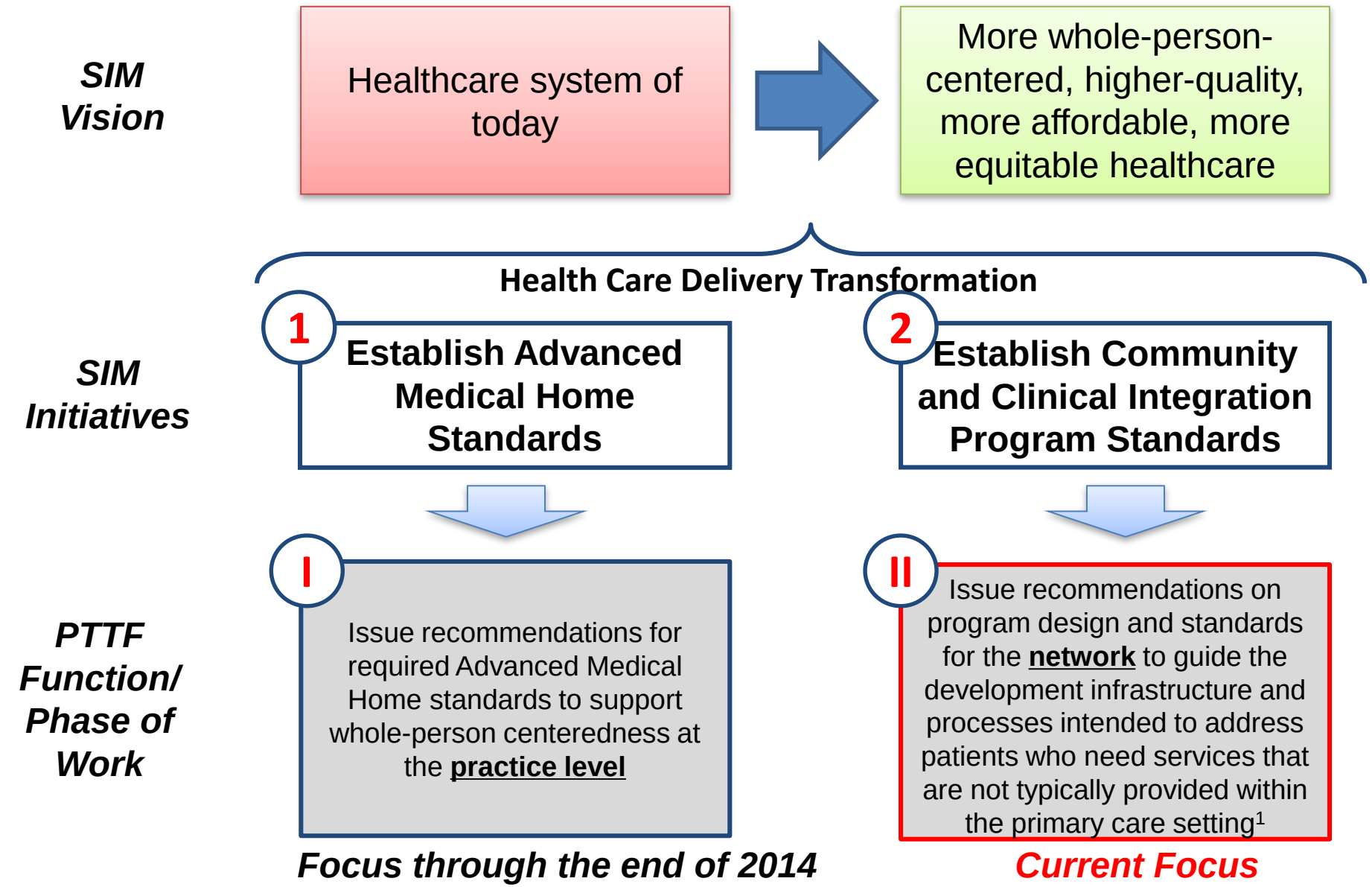
Connecticut will achieve this through seven strategic initiatives:

Pop Health Mgmt. | **Value Based Insurance Design** | **MQISSP** | **Quality Alignment** | **AMH Glide Path** | **CCIP** | **Consumer Engagement**

Payment reform to value based payments to promote/incentivize higher quality

Delivery system reform to support higher quality through care transformation at the practices and network levels

5. CCIP and Context of SIM



Notes:[1] This could include specialists that are outside the network (e.g.; behavioral health providers), clinically related support services (e.g.; pharmacists or dieticians), social support services (e.g.; housing or vocational assistance)

5. CCIP and Context of SIM

The CCIP will address the needs of more complex patients and patients currently experiencing gaps in care who need access to clinical services that may not reside within the network (e.g.; behavioral health) and community support services that help to address social barriers to care.

<u>AMH Standards will require that all patients have</u>:

- A comprehensive care assessment (Standard 3, Element C)
- A care plan that addresses needs (Standard 2, Element A)
- Provision of team based care to execute plan (Standard 2, Element D)

This will place patients on a continuum of care based on their health status

Good Health ⟷ **Poor Health**

Needs met within primary care practice

More intensive care needs that cannot be met by the primary care practice

Advanced Network/FQHC

Primary Care

Primary/ Specialty Care

Specialty Care

Illustrative

CCIP will create standards to integrate needed services into the network





Other Social Services

5. CCIP Progress and Activities To Date

The PTTF considered a) the broader objectives of CT SIM, b) the objectives of CCIP, and c) experiences in other states with similar programs in developing its approach to CCIP program design.

1 Identify Target Populations


Complex Patients


Patients Experiencing Equity Gaps


Patients with Mild to Moderate Behavioral Health Care Needs

2 Define Core Elements of Interventions for Target Populations


Multidisciplinary Team (with CHW) + Clinical – Community Linkages


CHW + Clinical – Community Linkages


Screening + referral to BH + confirm linkage to BH + follow-up

3 Design Intervention

4 Develop Standards for Intervention

To Be Discussed Today

5. CCIP Network Participation

- To be eligible for CCIP technical assistance support, the Advanced Network or FQHC must be participating in the Medicaid shared savings program (MQISSP)

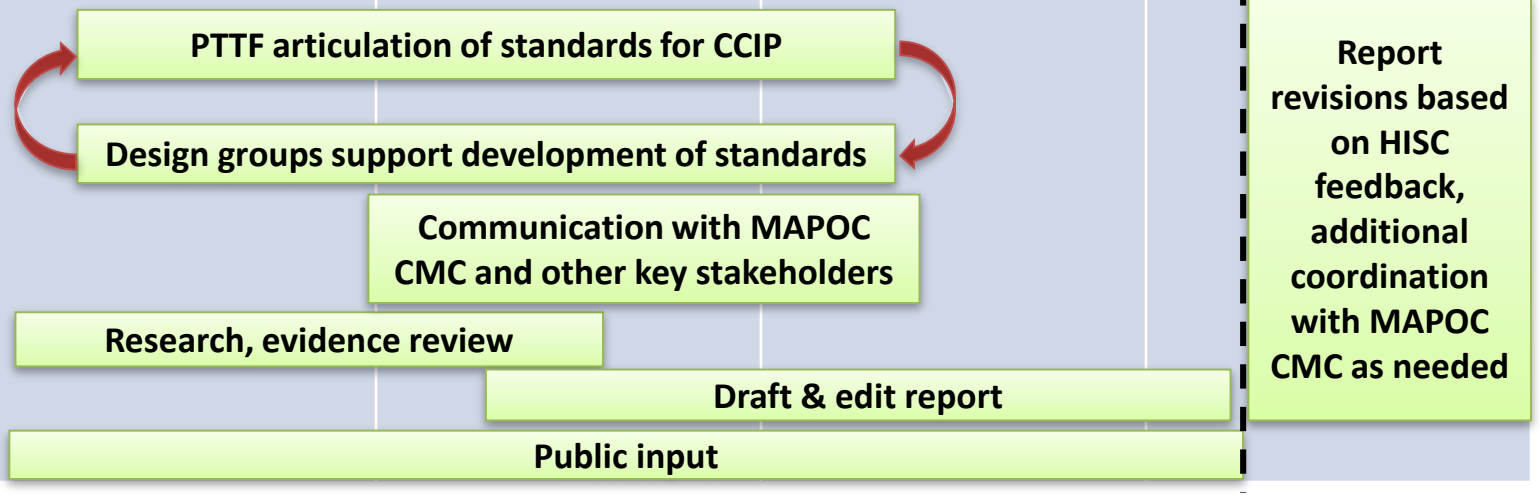
- Advanced Network or FQHC will apply for the CCIP technical assistance through the MQISSP RFP process

- While all AN/FQHC CCIP programs have to be participating in MQISSP, the CCIP resources will be available to all patients regardless of who their insurer is (i.e. Medicare, Medicaid, commercial)

5. CCIP Timeline

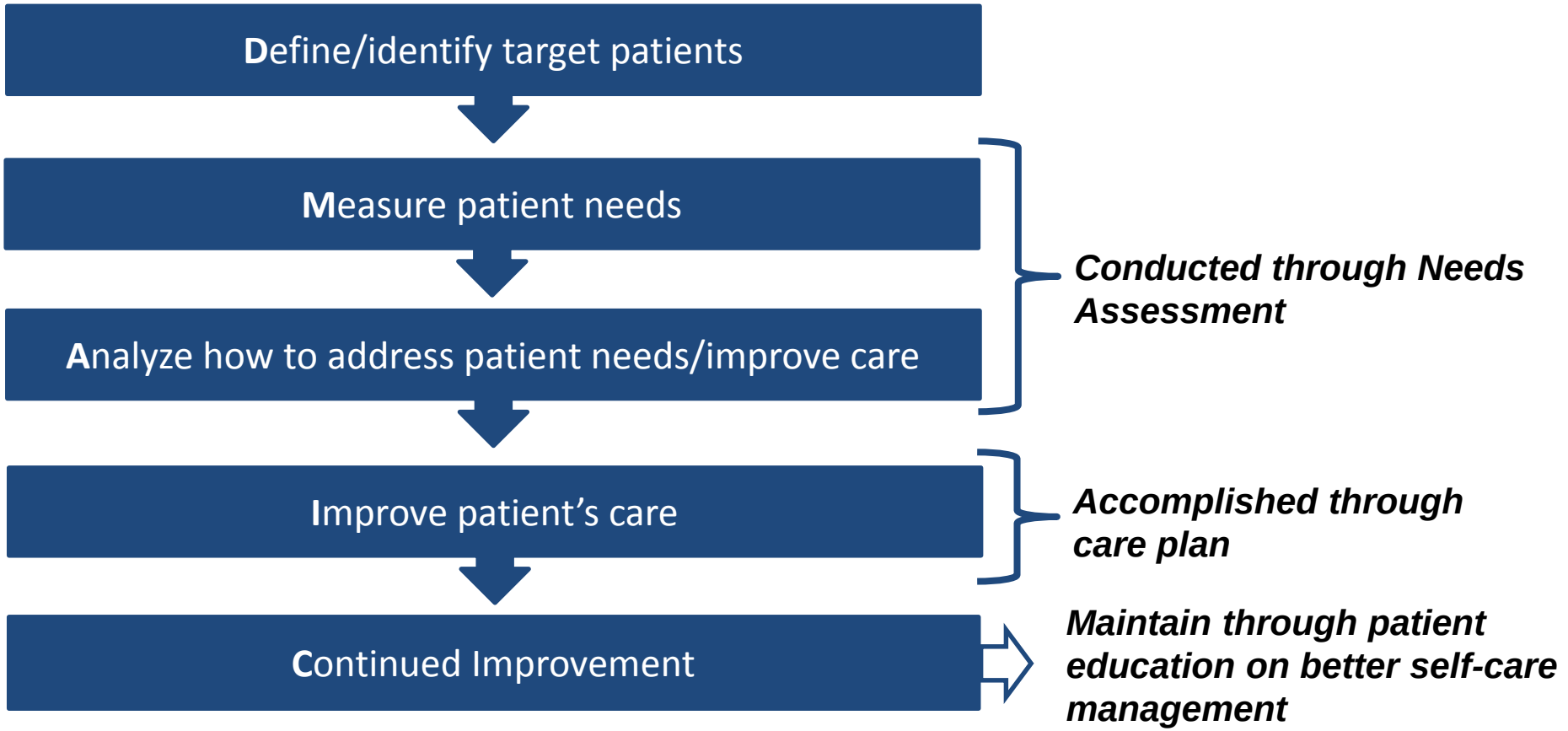
PTTF-CCIP Timeline

	July	Aug	Sept	Oct
PTTF Meetings	28	-	1	-
CCIP Design Sessions	16	6 (DG 2) 19 (DG3)		
Key Activities				

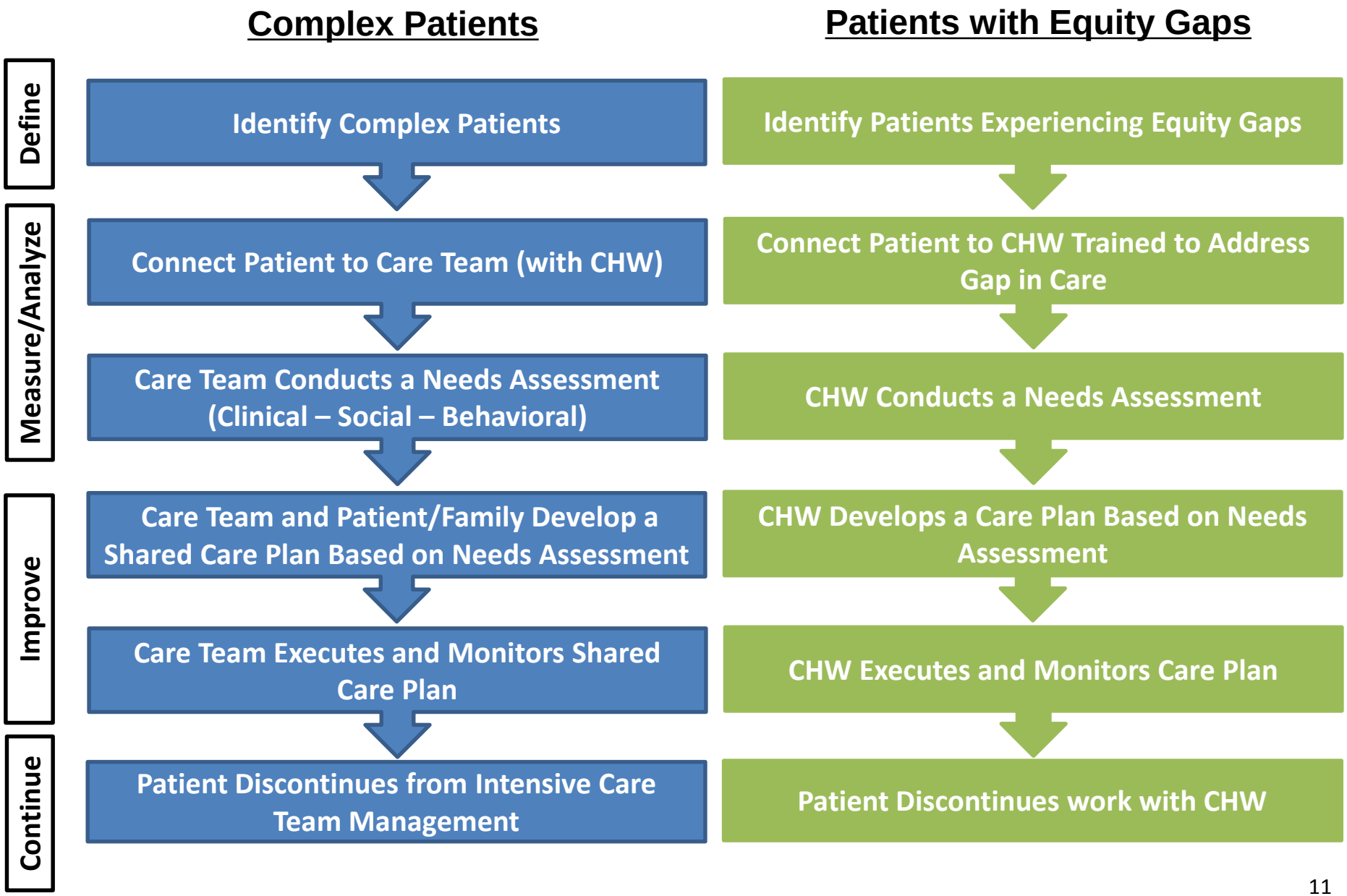


6. Program Design: Improving Care for Target Populations

To improve care for the individual patients in the target population, complex patients or patients experiencing equity gaps, a general process improvement approach can be employed that draws on tools commonly used to evaluate and improve patient care.



6. Program Design: Complex Patients and Equity Gaps



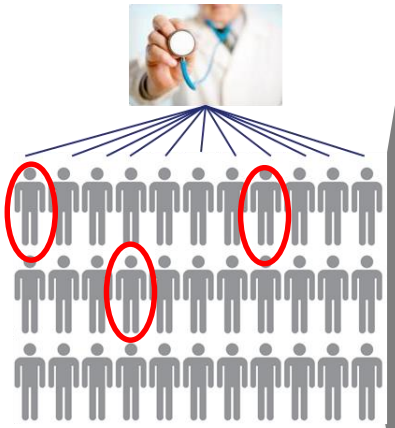
6. Program Design: Complex Patients and Equity Gaps

There are a range of options that advanced networks/FQHCs can use to identify their target populations. What is implemented will largely depend on what health information they have access to and the supporting information technology infrastructure.

Minimum

Optional

How will complex and/or patients with equity gaps be identified?



Attributed Network Population

Range of Options Requiring Varying Levels of Technology

	Referral	Manually Applied Criteria	Basic Analytics	Complex Analytics
Complex	• Based on professional judgement patient is flagged for program	• Manual method to flag high risk/complex patients developed (e.g.; > 2 IP admissions in 6 months) • Criteria applied in checklist form	• Risk stratification to identify high risk/potentially complex patients • Additional analysis if necessary to confirm "complex"[1]	• Predictive analytics to pre-emptively identify patients at risk for becoming complex
Equity Gaps		• Mining of claims data, chart review and physician referrals to identify gaps in care	• Stratify patients by OMB sub-populations[2] • Compare disease state outcomes	• Stratify patients by OMH sub-populations[2] • Compare disease state outcomes

Notes: 1) Consider number of chronic conditions, access issues, social supports, homelessness, medications; 2) OMB are the basic 7 race categorizations and OMH includes more specific sub-population categorizations like gender, disability and literacy

6. Program Design: Complex Patients and Equity Gaps

Suggested Standards for Discussion		
#	Complex	Equity Gaps
1	Where capabilities exist, establish a risk stratification methodology to identify high-risk/complex patients. As an alternative, develop inclusion/exclusion criteria and establish a process to apply the criteria.	At a minimum, establish the analytic capability to stratify patients by OMB sub-populations and develop analytic method to compare disease state outcomes (disease states TBD) to identify populations experiencing gaps in care.

	• Consider including the following in risk assessment:
	  • Utilization
	  • Chronic conditions
	  • Access to care
	  • Social circumstances
	  • Homelessness
	  • Insurance status	

6. Program Design: Complex Patients and Equity Gaps

In the case of complex patients, connecting the patient to the multidisciplinary team will require defining the core members of that team.

CCIP Design Question	Options
Who should the multidisciplinary team members be?	 Manager to provide oversight?  **Social Worker** *Supports identification of social and behavioral needs and case management*  **Nurse (RN)** *Supports clinically focused care coordination and management* CHW **CHW** *Supports care coordination and management of social needs and patient education*

Design Group One Input

- Many complex patients have behavioral health needs
- Include team member who has behavioral education or additional team member with behavioral health focus

Many teams also have non-core members who support care depending on the needs of the patient (e.g.; dieticians or pharmacists)

6. Program Design: Complex Patients and Equity Gaps

Suggested Standards for Discussion		
#	Complex	Equity Gaps
2	Identify members of the multidisciplinary care team	n/a

	• At a minimum these members should include:
	  • An RN to manage clinically focused care coordination and management
	  • A social worker to assess social needs of the patient including current systemic supports impacting the gaps care as well as patient's ability to self-manage the care regimen
	  • A community health worker (CHW) to coordinate access to social services and represent the patient's non-clinical needs (social, environmental, etc.) to the rest of the care team
	  • Ideally CHW and SW have some level of behavioral health training
	• Develop access to non-core members (e.g.; dieticians, pharmacists) as needed by patients	

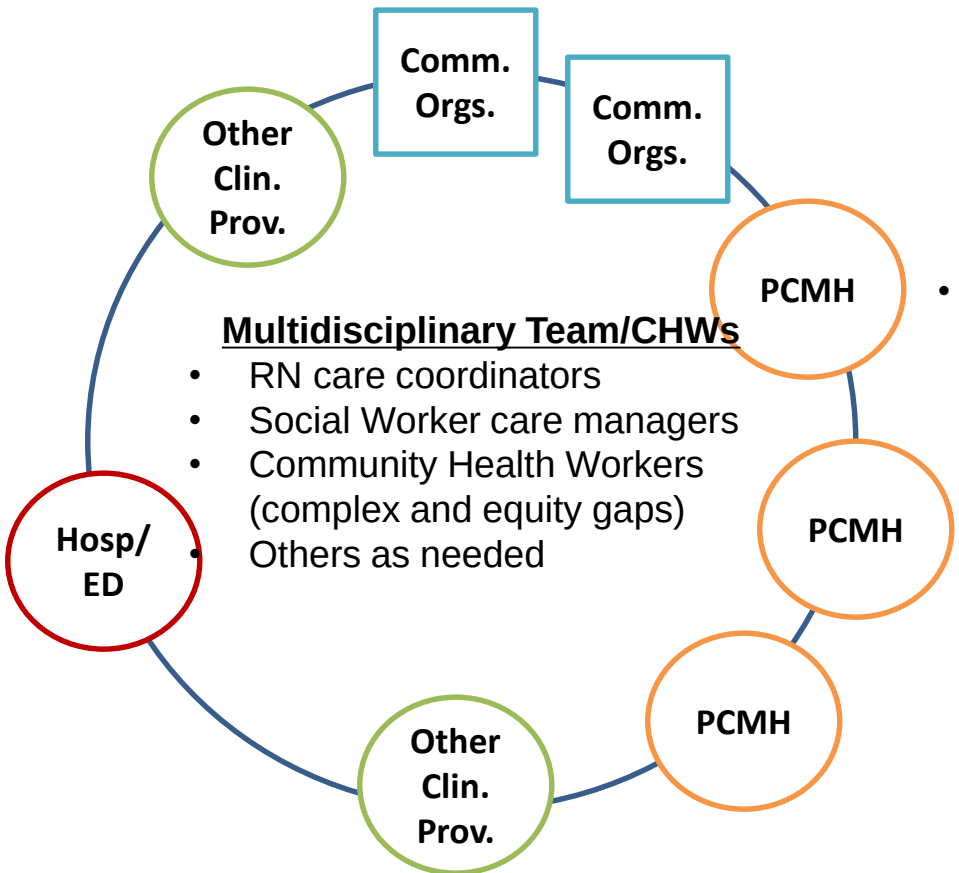
6. Program Design: Complex Patients and Equity Gaps

Building a multidisciplinary care team within each practice to address complex patient needs or employing CHWs to address equity gaps will likely present a resource challenge for most and depending on the practice size and needs would likely be an inefficient use of resources.

How are teams built and deployed?

Advanced Network/FQHC

Illustrative



Multidisciplinary Team/CHWs

- RN care coordinators
- Social Worker care managers
- Community Health Workers (complex and equity gaps)
- Others as needed

Design Considerations:

- **Should multidisciplinary care team be centralized at the network level?**
  - *Larger practices* may have care team members *within practices* currently who can be utilized
  - *Smaller practices* likely do not have the same resources and would benefit if the resources were *built at the network level*
- **Should all team members be employed by the network?**
  - Important to the CHW role is finding an individual *who represents the community* and/or cultural background of the patient
  - In the case of patients with equity gaps, the CHW will also need *specific disease state training*
  - Employing CHWs in a productive manner who can meet all patient needs could present a challenge
  - A *contract with an organization who employs CHWs* may be more efficient than employment

6. Program Design: Complex Patients and Equity Gaps

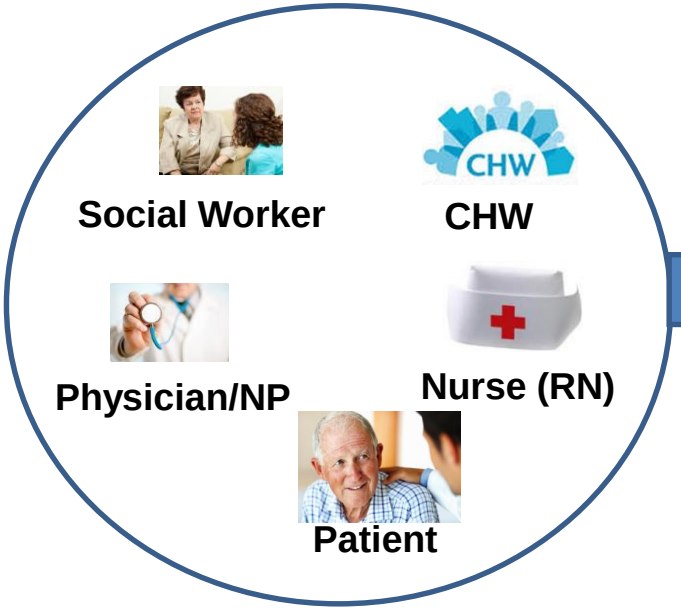
Suggested Standards for Discussion		
#	Complex	Equity Gaps
3	Draft and implement process to deploy multidisciplinary care team members to practices that have complex patients	Draft and implement process to deploy community health workers to practices with patients experiencing equity gaps
	• Conduct an assessment of practices with greatest needs and develop multidisciplinary team in most efficient manner to support those practices (i.e.; centrally support team or embed into practice) • Develop appropriate contracts (e.g.; MOU, BAA) with care team members if they are not employed by the network	• Develop appropriate contracts (e.g.; MOU, BAA) with CHW organization to support the needs of the Advanced Network/FQHC
4	Draft and implement the process for connecting patients to the multidisciplinary care team	Draft and implement process for connecting patients to the Community Health Worker

6. Program Design: Complex Patients and Equity Gaps

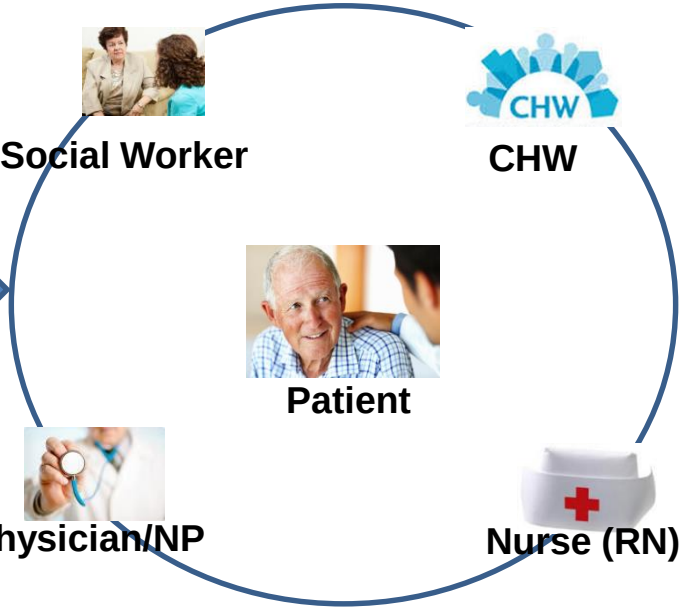
The most important element of training for providers caring for complex patients and patients experiencing equity gaps will be on how to best work as a team.

What training and education should be required?

Current



Future



While all these providers currently work with patients, it is not always done in a coordinated manner to address the fairly specific needs of a target population

Training and/or education for team based care that supports all the necessary providers to adopt a new workflow will support improved patient outcomes

Additional Benefits

- Will support clear definition of the scope of work and necessary training and skills required of each team member
- Standards for training/education may improve likelihood of reimbursement

6. Program Design: Complex Patients and Equity Gaps

Suggested Standards for Discussion		
#	Complex	Equity Gaps
5	Develop standardized training protocols for team based care focused on how core team members will interact	Develop standardized training protocols for team based care focused on how CHWs and primary care providers will interact
	• Document that training has occurred	• Document that training has occurred
6	Through the development of job descriptions, clearly identify roles and responsibilities (i.e.; scope of work) for each multidisciplinary care team member	Through the development of job descriptions, clearly identify roles and responsibilities (i.e.; scope of work) for the Community Health Worker
7	The community health worker should receive certification (type of certification required will should be determined by the AN/FQHC and/or the contracted CHW organization)	The community health worker should receive certification (type of certification required will should be determined by the AN/FQHC and the contracted CHW organization) and should have appropriate training in the diseases state of the equity gap being addressed

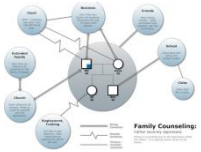
6. Program Design: Complex Patients and Equity Gaps

Crucial to a whole-person centered approach to patient care is a thorough understanding of what has led to the patient's current health care status and the barriers to improving upon their current status. This is of particular importance for patients who are currently not receiving optimal care.

What are the best practices for understanding current needs and assessing a patient's history?

Needs Assessment

- **Clinical**
- **Behavioral**
- **Social** (e.g.; transportation, housing, food, home care needs)



Eco-Map

- **Assessment of all patient supports** (i.e.; every provider who has "touched" the patient – past and present)
- **Synthesizes patient's current state**

Particularly useful for complex patients

6. Program Design: Complex Patients and Equity Gaps

Suggested Standards for Discussion		
#	Complex	Equity Gaps
8	Develop a needs assessment that evaluates the patient's clinical, social, and behavioral needs	Develop a needs assessment that evaluates the patient's social and behavioral needs with an emphasis on social and behavioral barriers leading to equity gaps
	• The clinical assessment should cover overall health status and needed improvements • The behavioral assessment should cover mental health, substance abuse and trauma • The social assessment should cover family/social/cultural characteristics, communication needs (including language needs), behaviors affecting health, assessment of health literacy, and barriers to care	• The needs assessment should focus on behavioral and social (in particular cultural and language needs) needs that are impacting the clinical area in which the AN/FQHC has identified equity gaps • The behavioral assessment should cover mental health, substance abuse, and trauma • The social needs assessment should cover family/social/cultural characteristics, communication needs (including language needs), behaviors affecting health, assessment of health literacy, and barriers to care
9	Develop an eco-map	n/a

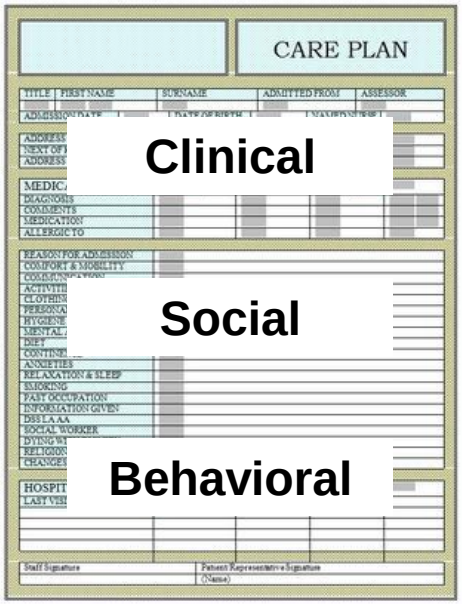
6. Program Design: Complex Patients and Equity Gaps

Suggested Standards for Discussion		
#	Complex	Equity Gaps
10	Draft and implement a process for administering the needs assessment and eco-map	Draft and implement a process for administering the needs assessment
	• Identify person(s) responsible for administering the needs assessment/sections of the assessment • Identify person(s) responsible for completing the eco-map	• The needs assessment should be conducted in the patient's home by the Community Health Worker • The assessment should be made available by electronic means to the patient's primary care team

6. Program Design: Complex Patients and Equity Gaps

Developing treatment goals for the patient that are informed by the needs assessment will support care improvement.

What are the best practices for setting and monitoring care goals for patients?



Design Questions	Best Practice
What should the care plan include?	• Care plan should reflect the needs assessment and eco-map (in the case of complex patients) • Care plan should clearly state treatment goals and the associated timeframe for completion
Who should complete the care plan?	• Care plan should be developed with input from all care providers (identified by eco-map) and patient/family • Ideal situation is to do a case conference with the patient and all providers to set treatment goals for next 3-6 months and identify who is responsible for working with the patient on each goal

6. Program Design: Complex Patients and Equity Gaps

Suggested Standards for Discussion		
#	Complex	Equity Gaps
11	Develop template for shared care plan	Develop template for shared care plan
	• The care plan should clearly map to the needs identified through the needs assessment • The care plan should have an improvement plan for patients with treatment goals, timeline for completing the stated goals, and an individual on the care team responsible for supporting the patient to achieve those goals	• The care plan should clearly map to the needs identified through the needs assessment • The care plan should have an improvement plan for patients with treatment goals, timeline for completing the stated goals, and state whether the CHW or primary care team member is responsible for supporting the patient to achieve those goals

6. Program Design: Complex Patients and Equity Gaps

Suggested Standards for Discussion		
#	Complex	Equity Gaps
12	Draft protocol that identifies which care team member is responsible for each part of the care plan and policies for completing the care plan	Draft and implement process for CHW to complete shared care plan
	• Hold care conference to complete care plan • Care conference should include the care team, all other relevant providers, and the patient • During the meeting determine which team member responsible for supporting the patient to achieve each goal	• Hold care conference to complete the care plan • Care conference should include the CHW, relevant primary care team members, and the patient • During the meeting determine who is responsible for supporting the patient to achieve each goal on the care plan

6. Program Design: Complex Patients and Equity Gaps

Once the shared care plan is developed, successful execution will require efficient communication with the patient and among the care team members (who will often work out of different locations and organizations).

What are the best practices for communication with the patient and the care team?

Care Team Meetings

Do these meetings have to occur in person?

How frequently should they occur?

What should be discussed at these meetings?

Patient Progress Update Visits

Where should these meetings occur?

How frequently should they occur?

How/where are outcomes of these meetings documented?

Information Sharing

How is information shared/made available electronically to all relevant providers (care team and community partners)?

Where are updates/progress notes to the care plan documented?

6. Program Design: Complex Patients and Equity Gaps

Suggested Standards for Discussion		
#	Complex	Equity Gaps
13	Draft and implement a policy/protocol for care team meetings	Draft and implement a policy/protocol for CHW and primary care team meetings
	• Establish frequency of full care team meetings • Identify meeting setting (i.e.; in person; telephonic solution) • Create standardized agenda that covers a review of patient progress on care plan, surfaces barriers to success, and identification of solutions • Consider re-evaluation of needs and revision of care plan with patient at certain time intervals	• Establish frequency of meetings with CHW and primary care team • Identify meeting setting (i.e.; in person; telephonic solution) • Create standardized agenda that covers a review of patient progress on care plan, surfaces barriers to success, and identification of solutions • Consider re-evaluation of needs and revision of care plan with patient at certain time intervals

6. Program Design: Complex Patients and Equity Gaps

Suggested Standards for Discussion		
#	Complex	Equity Gaps
14	Draft and implement a policy/protocol for care team member's interaction with the patient	Draft and implement a policy/protocol for CHW's and primary care team's interaction with the patient
	• Establish expectation for how frequently care team member's should interact with the patient • Establish expectation for where team member's should interact with the patient (i.e.; home, via phone, etc.)	• Establish expectation for how frequently CHW and primary care team should interact with the patient • Establish expectation for where CHW should interact with the patient (i.e.; home, via phone, etc.)
15	Draft protocol and develop/utilize relevant technology for communication between care team members and other relevant providers	Draft protocol and develop/utilize relevant technology for communication between CHW, primary care team, and other relevant providers
	• Establish where updates to care plan and other patient related notes will be documented • Develop capability and process to share relevant patient information with care team and community partners	• Establish where updates to care plan and other patient related notes will be documented • Develop capability and process to share relevant patient information with primary care team and community partners

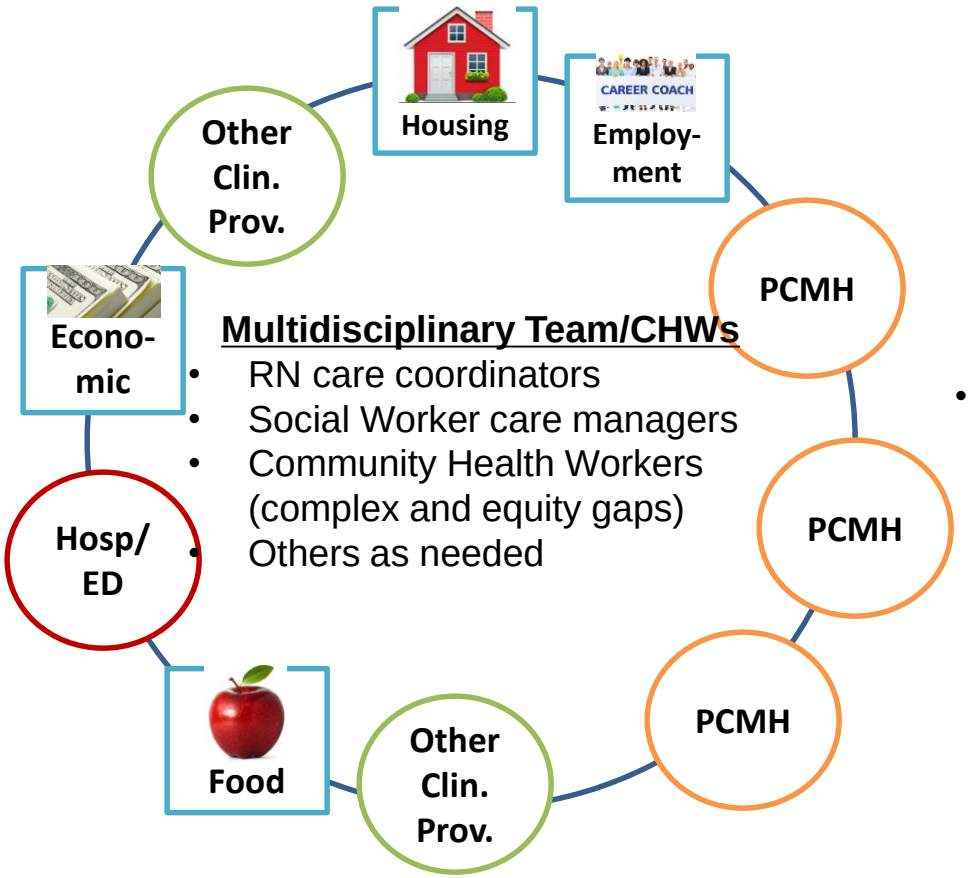
6. Program Design: Complex Patients and Equity Gaps

Given the impact social circumstances can have on health outcomes, it is crucial that the network develop relationships with key social support services.

What type of relationships should be established with community partners?

Advanced Network/FQHC

Illustrative



Multidisciplinary Team/CHWs

- RN care coordinators
- Social Worker care managers
- Community Health Workers (complex and equity gaps)
- Others as needed

Design Considerations:

- **2-3 organizations with which relationships will be required**
  - *Complex:* Housing, Employment, Food
  - *Equity Gaps:* Housing, Food, Economic Assistance
  - Business Associates Agreement (BAA) to allow the sharing of patient information
  - Memorandum of Understanding (MOU) outlining the terms of the relationship
- **Other organizations with which network should be familiar with**
  - Based on patient needs other social services outside of the 2-3 being recommended might also be needed
  - Assign a team member to be responsible for maintaining an inventory of relevant community resources

6. Program Design: Complex Patients and Equity Gaps

Suggested Standards for Discussion		
#	Complex	Equity Gaps
16	Develop and execute relationships with housing, nutrition, and vocational assistance organizations	Develop and execute relationships with housing, economic, and nutrition assistance organizations
	• Details of relationships TBD by Design Group 2	• Details of relationships TBD by Design Group 2
17	Draft and implement guidelines for connecting patients with other community resources with which the Advanced Network/FQHC does not have formal linkages with	Draft and implement guidelines for connecting patients with other community resources with which the Advanced Network/FQHC does not have formal linkages with
	• CHWs should maintain a list of relevant community resources for the patient population they are serving • CHW is responsible for initiating the patient link to the needed resource and following up to ensure the patient received the necessary assistance • Referrals made and successfully completed should be tracked in the care plan	• CHWs should maintain a list of relevant community resources for the patient population they are serving • CHW is responsible for initiating the patient link to the needed resource and following up to ensure the patient received the necessary assistance • Referrals made and successfully completed should be tracked in the care plan

6. Program Design: Complex Patients and Equity Gaps

To promote continuous quality improvement, the CCIP programs should establish performance metrics. Performance should be reviewed and used to guide performance improvement strategy by the network and participants on a routine basis.

What is best practice for monitoring performance and improving care outcomes?

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. Should be shared with care team working with patient
Result?	Improvement opportunities identified and addressed

6. Program Design: Complex Patients and Equity Gaps

Suggested Standards for Discussion		
#	Complex	Equity Gaps
18	Develop program evaluation parameters and capabilities to be reviewed and updated on an annual basis	Develop program evaluation parameters and capabilities to be reviewed and updated on an annual basis

	• Develop process metrics (examples)
	  • # of enrollees out of eligible patients
	  • # of care plans completed for enrolled patients
	  • # of care team hours with patient
	• Outcome metrics at a minimum should include relevant metrics aligned with quality score card
	  • 30 day readmission
	  • ASC admissions
	  • ED use
		• Develop process metrics (examples)
		  • # of enrollees out of eligible patients
		  • # of care plans completed for enrolled patients
		  • # of CHW hours with patient
		• Outcome metrics at a minimum should include relevant metrics aligned with quality score card
		  • Health Equity Design metrics

19	Establish process to share performance with program participants and to utilize performance outcomes to inform ongoing performance improvement efforts	Establish process to share performance with program participants and to utilize performance outcomes to inform ongoing performance improvement efforts
20	Utilize a learning collaborative to assess patient needs/barriers to success that are preventing improved outcomes	Utilize a learning collaborative to assess patient needs/barriers to success that are preventing improved outcomes

6. Program Design: Complex Patients and Equity Gaps

The ultimate goal of is to improve each patient's current circumstances through patient education and effective self-management. Once this is accomplished, the patient likely will need less care management and achieve better outcomes

How will the network know when the patient has developed the necessary skills?

Through working with the multidisciplinary care team the complex patients will have…

- ✓ Been connected to needed social support services
- ✓ Engaged in his/her health care
- ✓ Developed self-management skills
- ✓ Achieved their goals on the shared care plan

Through working with a CHW patients with equity gaps will have….

- ✓ Been connected to needed social support services
- ✓ Barriers to care have been addressed (e.g.; health literacy, culturally competent education, etc.)
- ✓ Developed self-management skills
- ✓ Achieved their goals on the shared care plan

Develop an assessment to determine if patient is ready to manage their care independently

6. Program Design: Complex Patients and Equity Gaps

Suggested Standards for Discussion		
#	Complex	Equity Gaps
21	Develop or identify existing criteria to evaluate the patient's readiness to discontinue working with the multidisciplinary care team	Develop or identify existing criteria to evaluate the patient's readiness to discontinue working with the community health worker

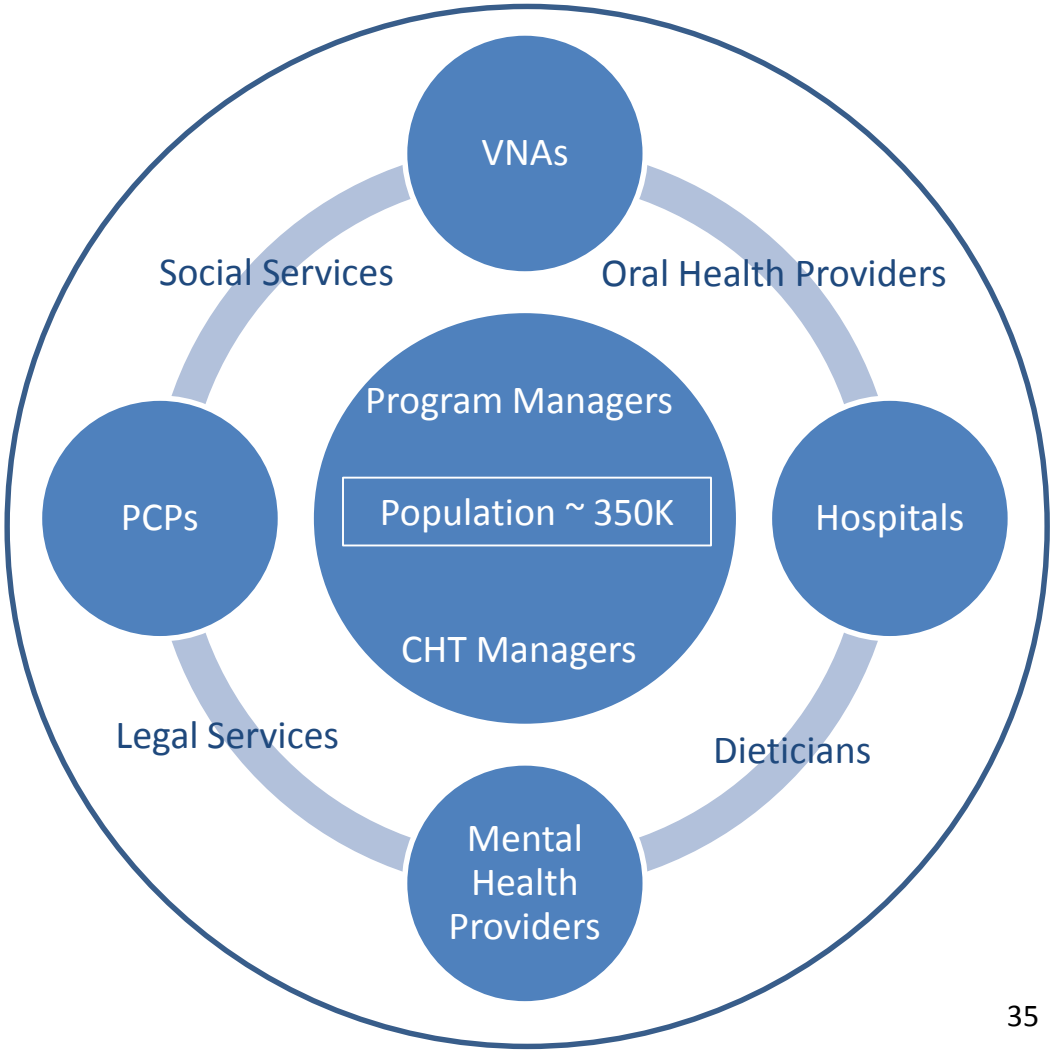
7. Vermont Case Study: Context & Strategy

Vermont placed population needs at center of its Community Health Team design w/ local infrastructure adjusted to meet local needs and form hub-&-spoke model

Core Features

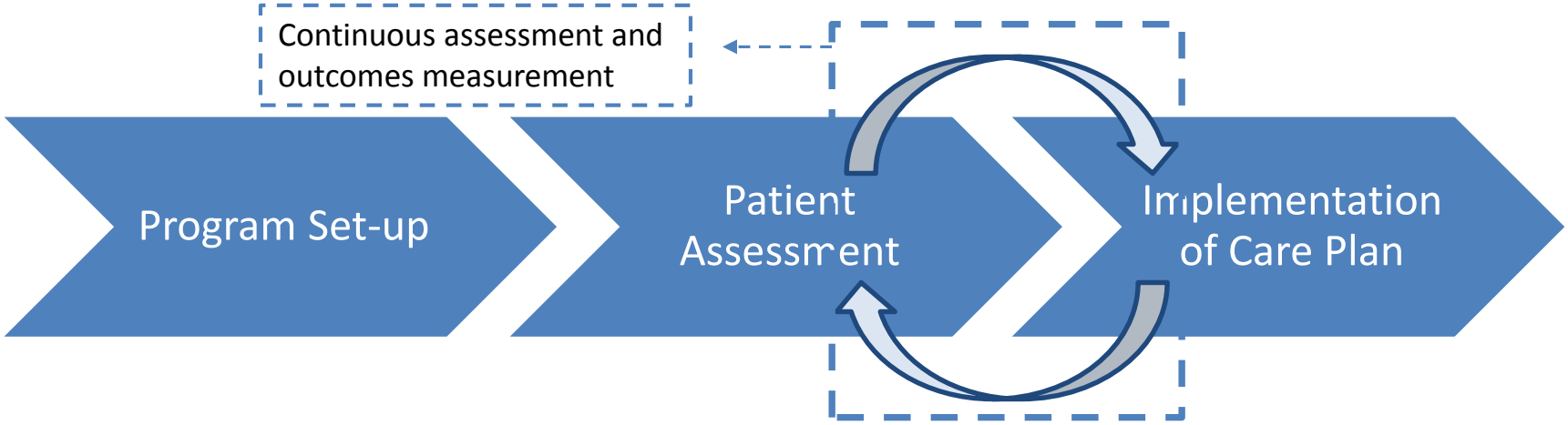
- Community Health Team (CHT) program pre-dates formation of ACOs
- Program Managers determine population needs and are responsible for design and program setup
- CHT managers are responsible for practice-level clinical procedures and protocols
- CHTs developed core teams with functional and extended designations for additional supports as needed
- State provided general guidance and basic supporting documents to allow local communities to determine governance
  - HIT and certain other statewide policies are enforced
- Hiring entity is one that receives CHT dollars with the enhanced primary care capabilities (usually hospital, sometimes FQHC)

Local Geographies



7. Vermont Case Study: Program Design

Local communities developed unique programs based off of infrastructure and needs but overall program design featured similar protocols



Actions
- PM convenes core providers
- PM determines gaps of care and establishes relationship with social service entities
- CHT Manager determines clinical protocols and
- PM coordinates any additional resources
- Local organizations, with TA from State, develop MOUs and formal agreements
- Local convening entity with PC capabilities hires staff

Actions
- Core team conducts root cause assessment of patient ideally back ~10 years to look for medical, social, mental, and systemic causes
- Development of a comprehensive care plan
- Core team member assigned to implement care plan with an eco-map of all providers
- Care plans and model documents inside PC EMR

Actions
- Central coordinator with additional team members supplement gaps in care including extended PC into home setting
- Regular care conferences determine patient progress with adjustments made when necessary

7. Vermont Case Study: Considerations for PTTF

VT's model faced similar issues as CT and presents a number of considerations for the PTTF

Challenges & Lessons in VT	Considerations for PTTF
• Technology challenges with the sharing of care plans was a major contributor to gaps in care because plan only resided in PC EMR	• Given evolving HIT limitations, the PTTF needs to consider enabling local practices to communicate in the most efficient and effective way
• Care conferences and updating POCs was a major contributor to managing complex patients and work best when the patient is not in crisis	• PTTF should encourage in-person, telephonic, or other telehealth care conferences with guidance for efficient use of time & agenda development
• Legal complexities attributable to local sensitivities to binding frameworks was too burdensome to manage and favored flexibility in local care design	• PTTF needs to assess environment and collaborative efforts to determine whether set legal frameworks are applicable statewide
• Medicaid administered Care Management services were not payer agnostic. This caused discontinuity or loss of essential support services with lost gains and recurrent crises	• PTTF needs to consider payer agnostic services where possible to ensure continuity of complex patient care
• Integration with existing programs, including ACOs, have caused problems, but the program design has allowed communities to determine whether to build, borrow, or buy resources	• PTTF needs to determine which core services could be shared across geographies and align them with other initiatives being implemented across the state

8. Next Steps

- Schedule additional design group one meeting to discuss the behavioral health intervention and the elective capabilities
- Consider adding another PTTF meeting
- Send draft of design standards to PTTF for feedback

9. Appendix: Index of Acronyms

Acronym	Acronym Defined
ACO	Accountable Care Organization
AMH	Advanced Medical Home
AN	Advanced Network
BAA	Business Associates Agreement
CCIP	Community and Clinical Integration Program
CHT	Community Health Team
CHW	Community Health Worker
EHR/EMR	Electronic Health Record/Electronic Medical Record
FQHC	Federally Qualified Health Center
MAPOC CMC	Council on Medical Assistance Program Oversight - Care Management Committee
MOU	Memorandum of Understanding
MQISSP	Medicaid Quality Improvement Shared Savings Program
OMB	Office of Management and Budget
OMH	Office of Minority Health
PCMH	Patient Centered Medical Home
PM	Program Manager
POC	Plan of Care
PTTF	Practice Transformation Taskforce
SIM	State Innovation Model
VBID	Value Based Insurance Design
VNAA	Visiting Nurse Associations of America