Practice Transformation Task Force:

Webinar to the Care Management Committee regarding the Community and Clinical Integration Program

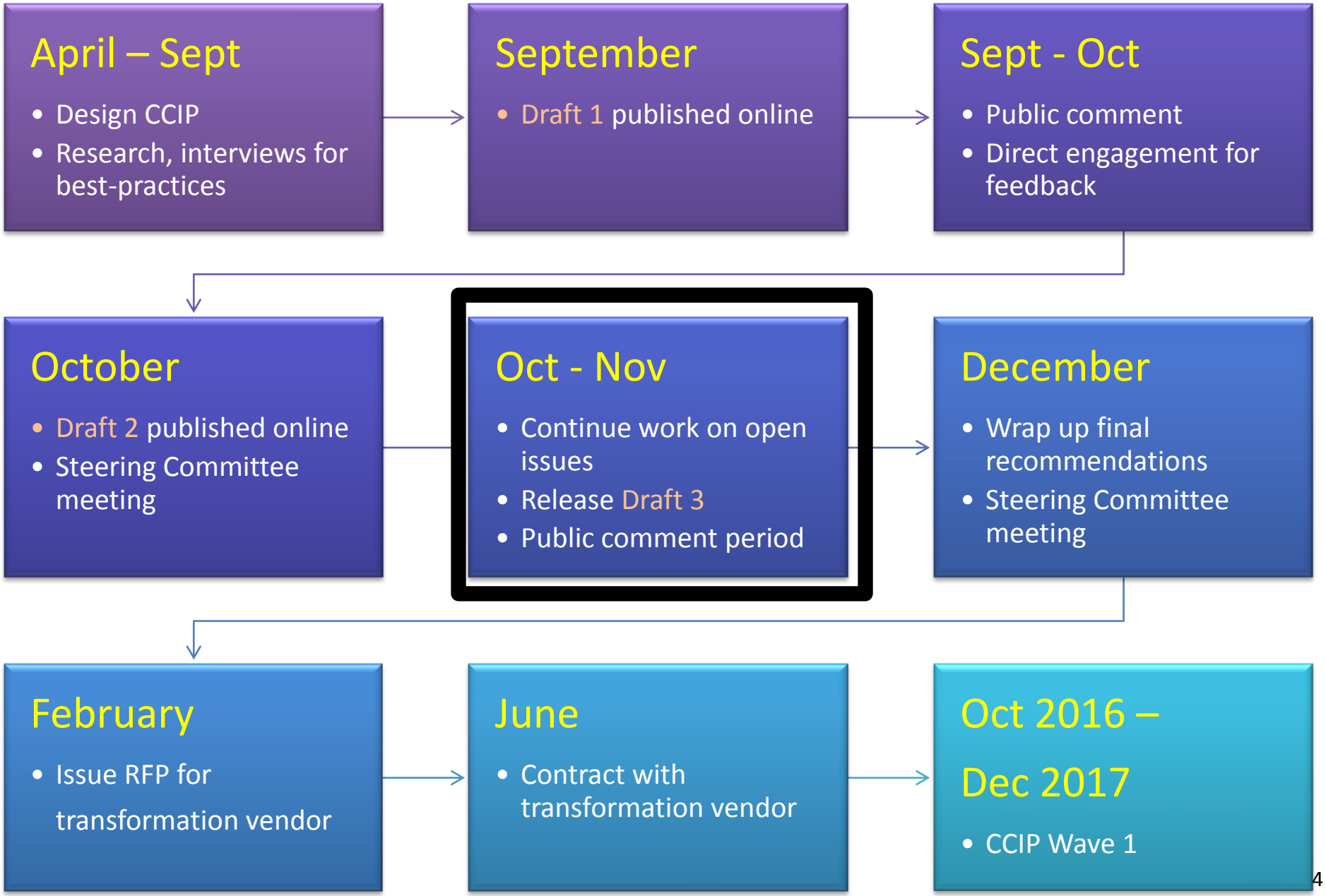
November 2, 2015

Meeting Agenda

Item	Allotted Time
1. CCIP Design & Timeline Update	5 mins.
2. CCIP Report Comment Process & CCIP Phases	10 mins.
3. Overview of CCIP	15 mins.
4. Review of Public Comments	10 mins.
5. Open Issues	5 mins.

CCIP Timeline and Design Process Update

1. CCIP Design High-Level Timeline



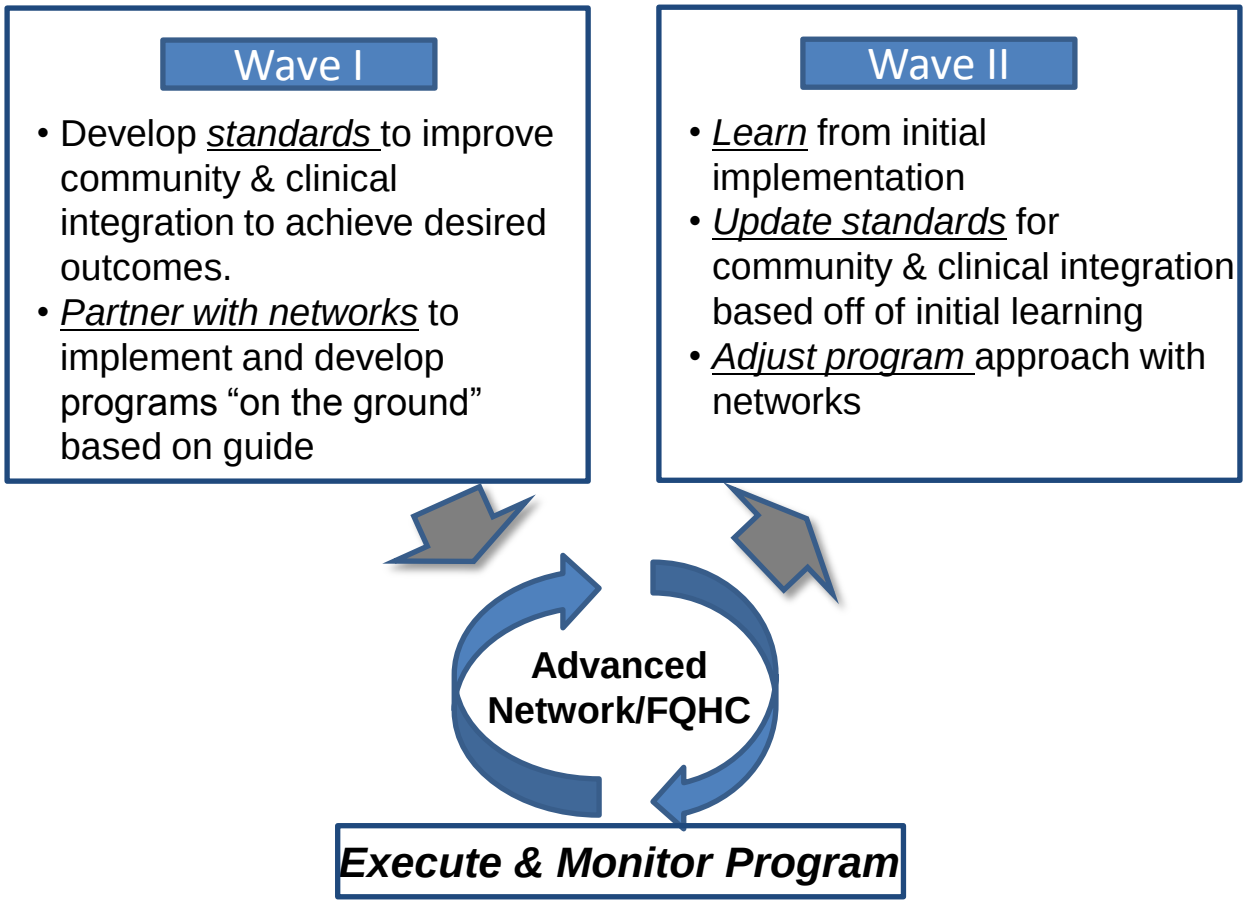
2. CCIP Report Comment Process (Sept-Oct)

The PTTF pursued two parallel avenues to collect, process, and incorporate feedback on the first draft of the report:

Public Comments	Direct Engagement with Partners and Stakeholders
• First draft report posted online	• Report circulated to PTTF, MAPOC CMC, and other SIM stakeholders
• Public notification of report's availability with a request for comment sent out	• Webinar to address feedback and questions with CMC
• Public comments received were posted online	• Engaged DPH and DSS on issues of joint concerns
• Summary of comments and PMO disposition to comments also posted online	• Summary of comments and responses distributed to PTTF
	• PTTF meeting to review comments in detail and discuss significant changes

CCIP Phases

CCIP will evolve. The integration community and clinical services at the network level is still relatively innovative and will require an iterative design process.



3. Overview of CCIP

Context of SIM

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

- Improve Population Health
- Promote Consumer Engagement
- Reduce Health Inequities
- Improve access, quality and patient experience
- Improve affordability by lowering costs

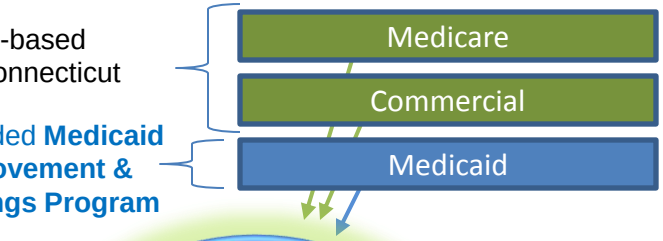
Connecticut State Innovation Model: Drivers towards Change (2016-2019)

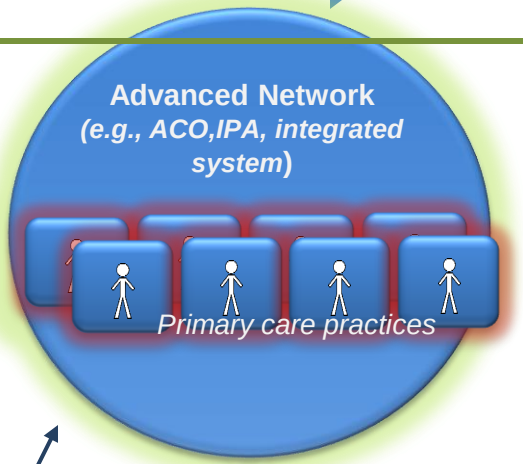
Targeted Initiatives

Promote alternative payment models that reward value

Existing value-based payment in Connecticut

New SIM-funded **Medicaid Quality Improvement & Shared Savings Program (MQISSP)**





2020 goal: 88% Medicaid panel in MQISSP

Strengthen the healthcare delivery capabilities of these Advanced Networks and FQHCs, while they are being rewarded to improve quality and reduce cost

- **Community & Clinical Integration Program (CCIP):** *Awards & technical assistance to support Advanced Networks & FQHCs to achieve standards in: care management; health equity improvement; behavioral health integration*
- **Advanced Medical Home (AMH) Program:** *Technical assistance (webinars, on-site) for non-medical home practices within Advanced Networks to achieve Patient Centered Medical Home NCQA 2014 recognition and additional requirements*
- **Data analytics and health information technology:** *Ensure Advanced Networks & FQHCs have the health information technology tools to succeed in value-based payment.*

Statewide Initiatives

Promote alternative payment models that rewards value

- **Core Quality Measure Set:** *Create a statewide multi-payer core quality measure set for payers to adopt, to provide consistency across their value-based payment models*
- **Data analytics and health information technology:** *Develop and deploy measurement and analytic solutions to support the use by all payers of EHR-based, outcome, health equity and care experience measures in value-based payment scorecards*

Engage consumers in healthy lifestyles, preventive care, chronic illness self-management, and healthcare decisions

- **Value-based Insurance Design (VBID):** *Accelerate "demand-side" reforms. Incentivize healthy choices by engaging employers to spread use of Value-Based Insurance Designs*
- **Common Scorecard:** *Provide transparency on cost and quality by creating a public common scorecard to report performance of ANs & FQHCs in value-based payment*
- **Consumer Engagement:** *Hold public meetings, focus groups, listening tours, and other outreach strategies for healthcare consumers and their new role in the transforming health system*

Strengthen healthcare delivery capabilities

- **Community Health Workers:** *Develop statewide infrastructure, policy recommendations, workforce systems, and health system integration strategies to promote CHWs*
- **Data analytics and health information technology:** *Enhance analytics and efficient health information sharing across the health neighborhood.*

Promote policy, systems, & environmental changes, and address socioeconomic factors that impact health

- ***Develop & implement:*** *financial incentive model to reward communities for health improvement.(HECs); measures for community health; and Prevention Service Centers.*

SIM Targeted Initiatives: Hypothesis

High percentage of patients in value-based payment arrangements

+

Resources to develop advanced primary care and organization-wide capabilities

=

Accelerate improvement on population health goals of better quality and affordability

MQISSP
Medicare SSP
Commercial SSP

+

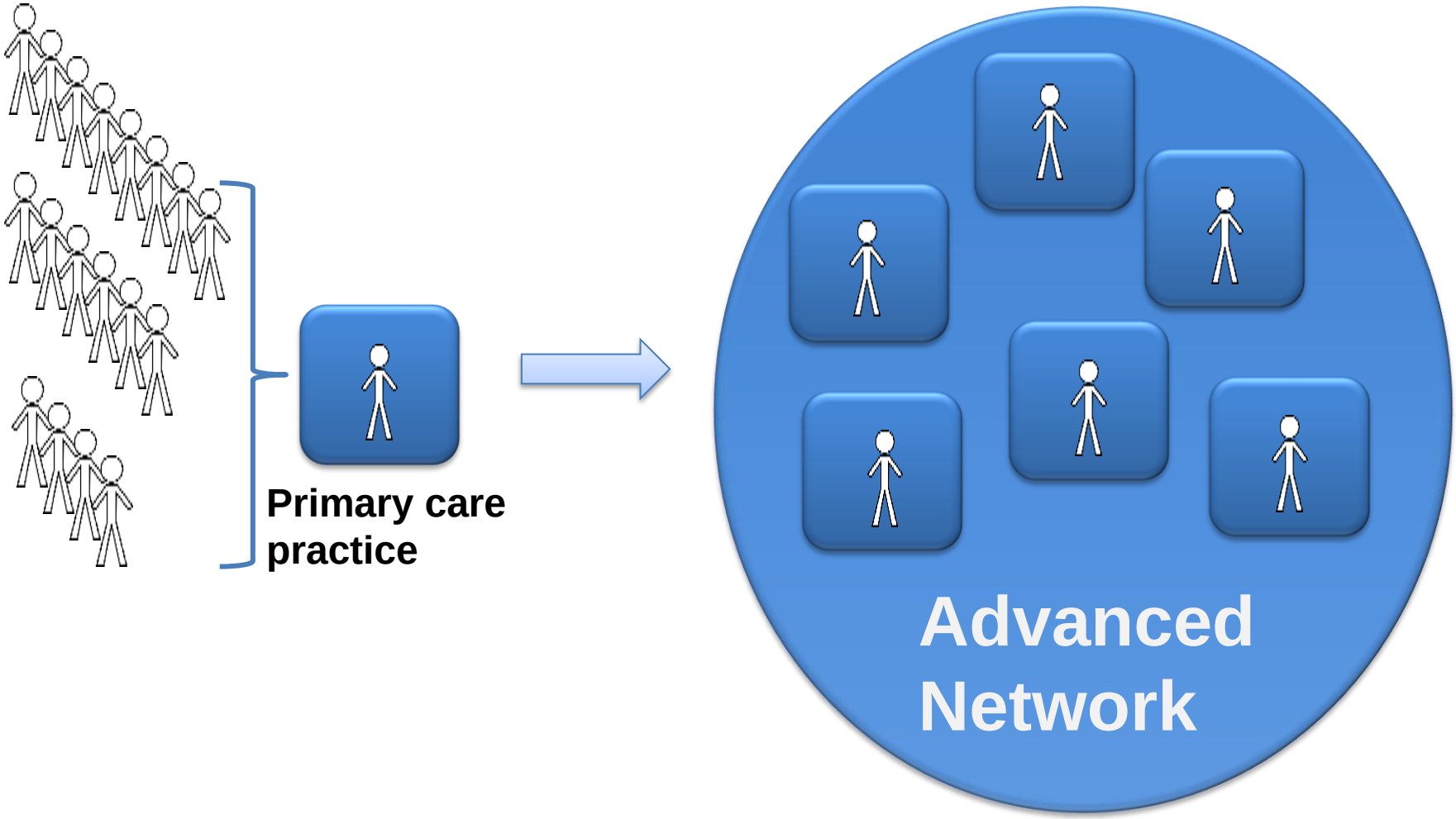
- **Advanced Medical Home Program**

&

- **Community & Clinical Integration Program (CCIP)**

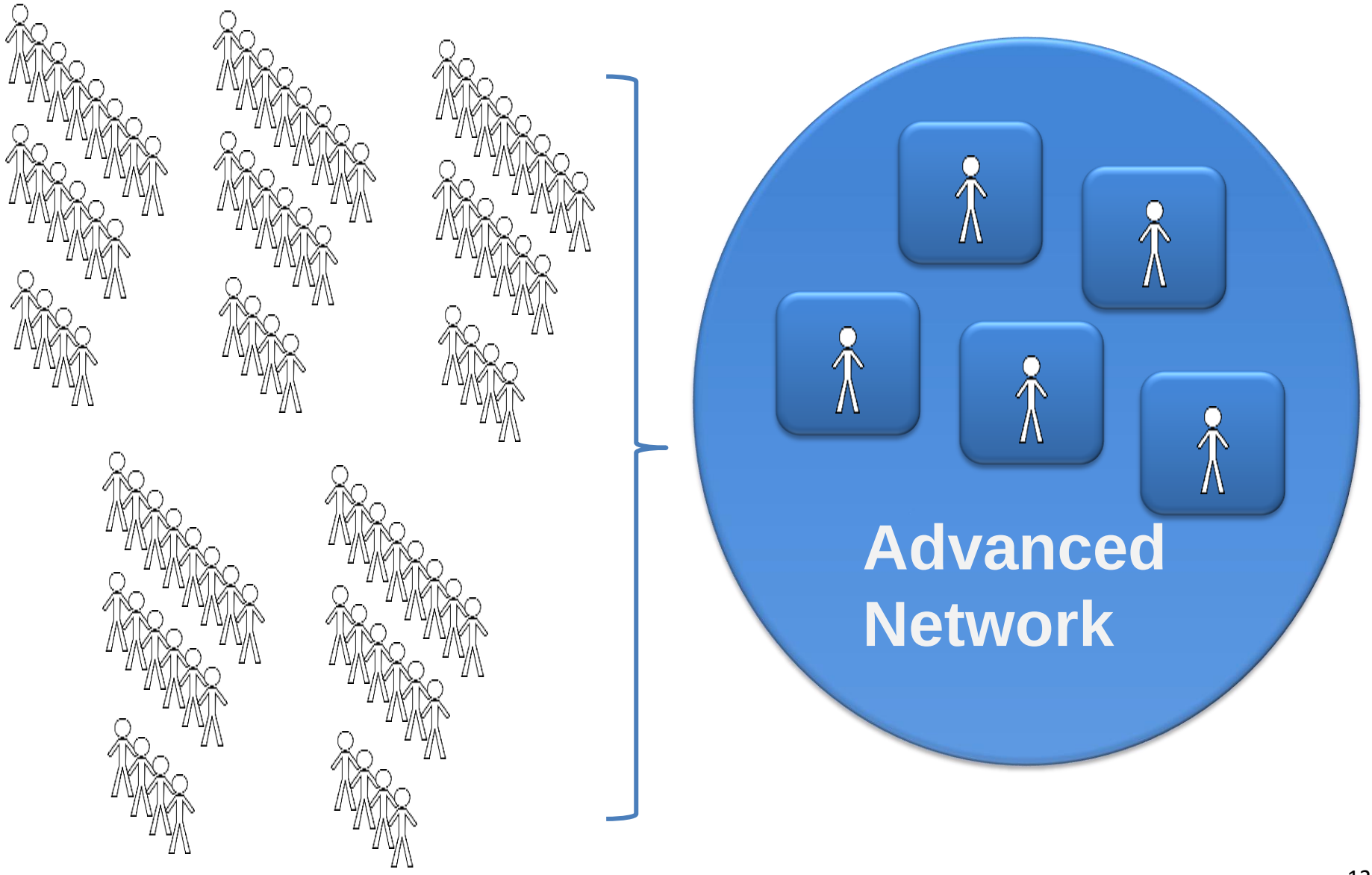
MQISSP is the Medicaid Quality Improvement and Shared Savings Program

Primary care partnerships for accountability



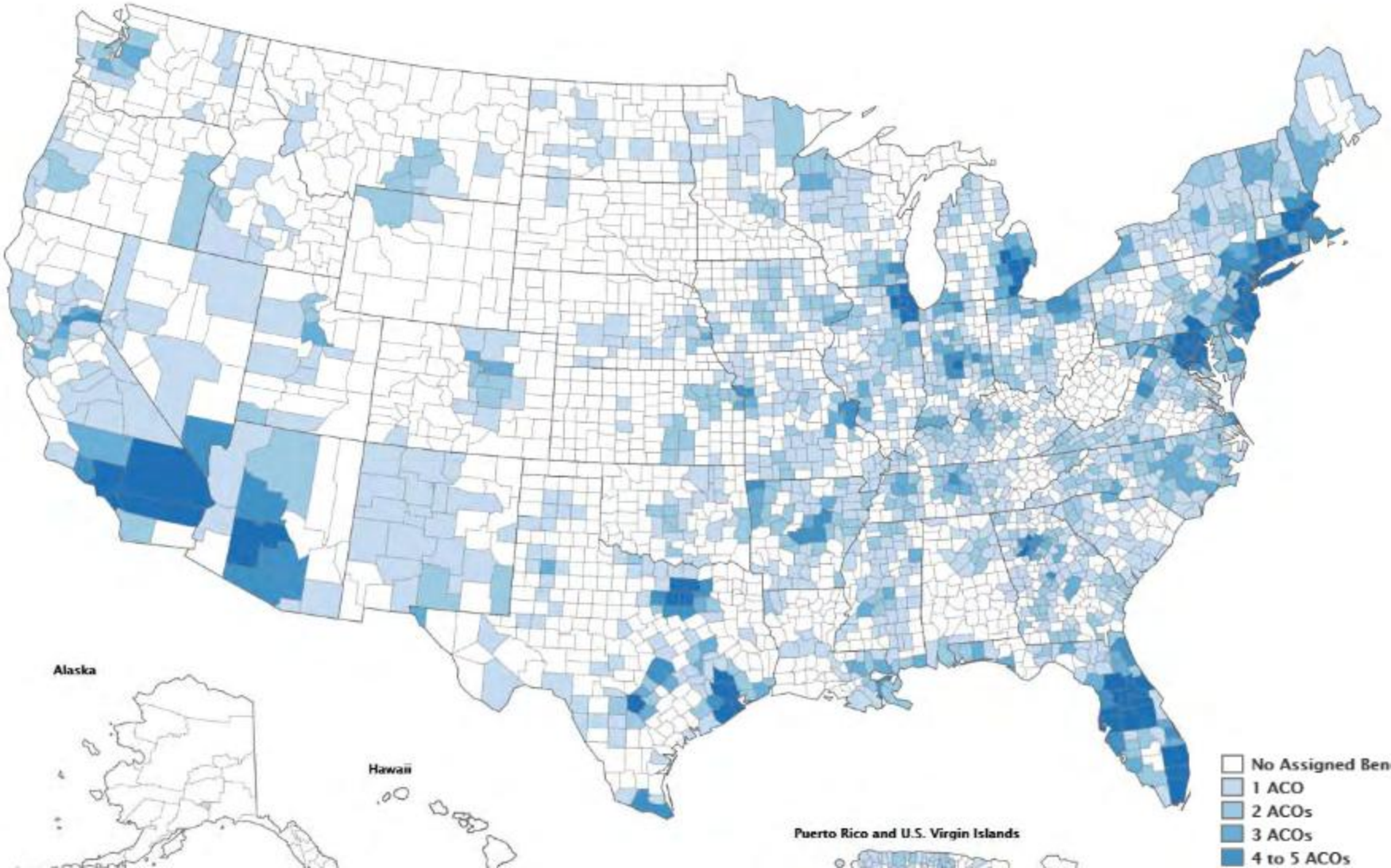
Advanced Network = independent practice associations, large medical groups, clinically integrated networks, and integrated delivery system organizations that have entered into shared savings plan (SSP) arrangements with at least one payer

Accountability for quality and total cost

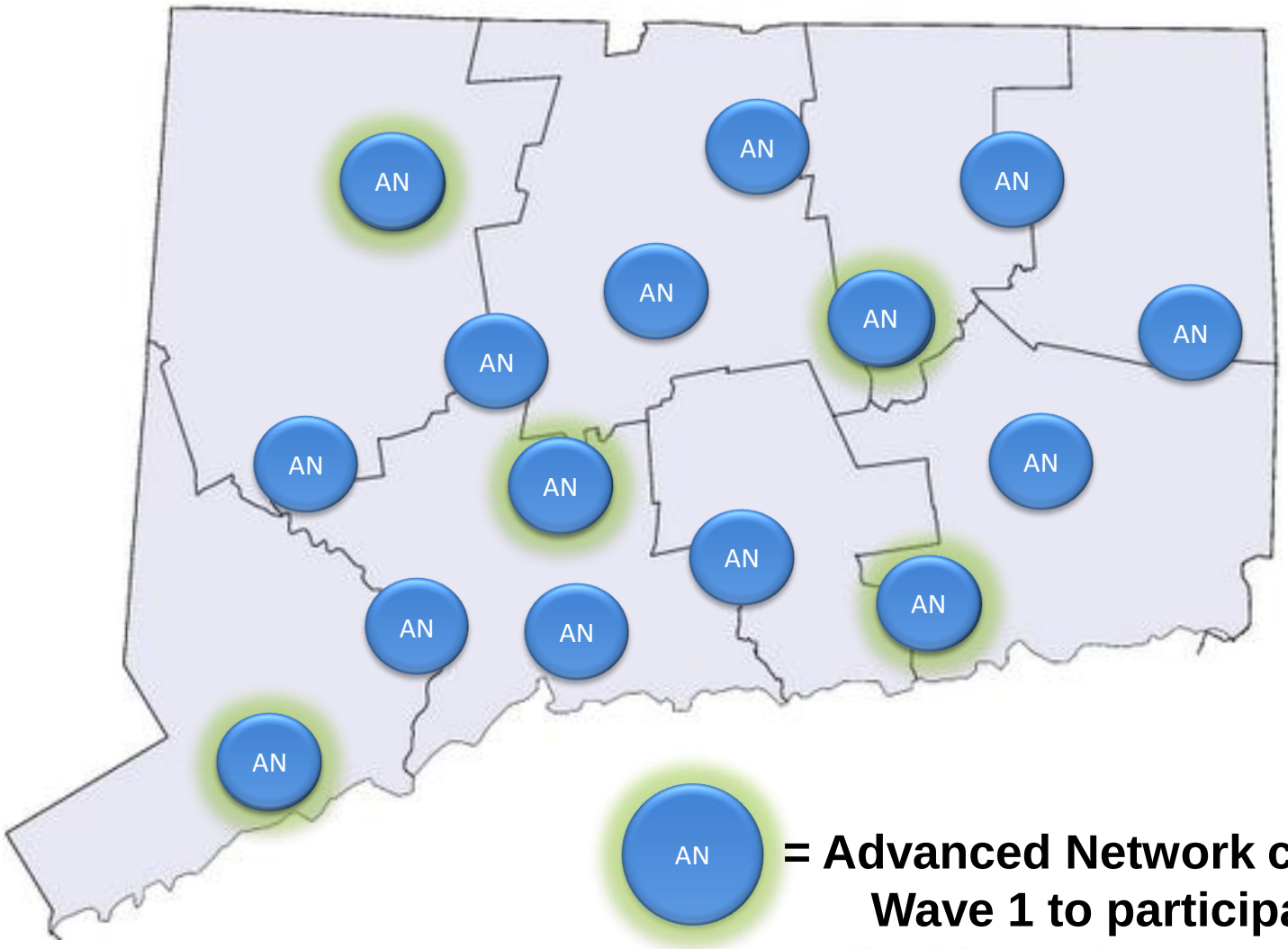


Medicare Shared Savings Program ACO Assigned Beneficiary Population by ACO by County

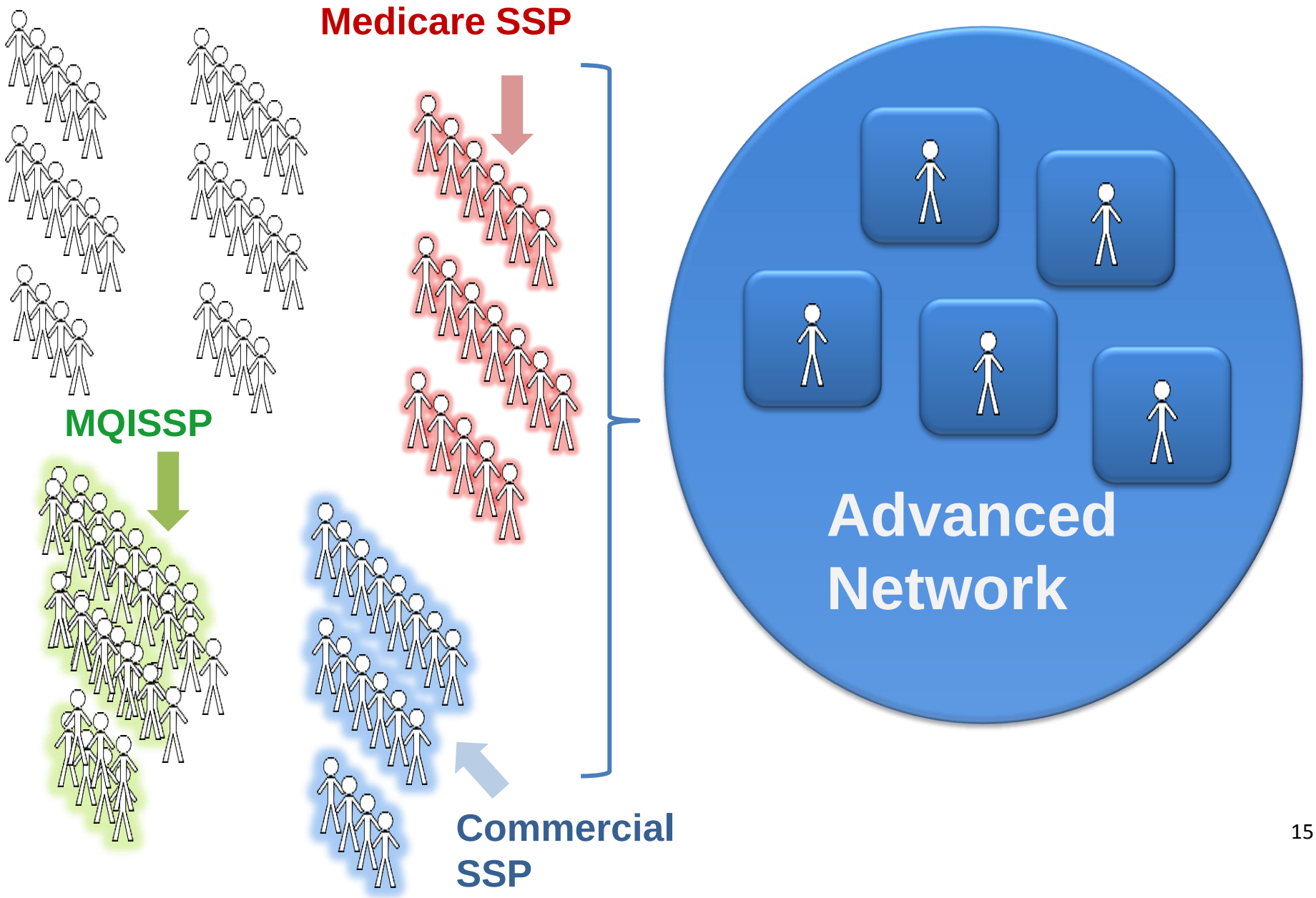
(counties with more than 1 percent of an ACO's assigned beneficiaries)



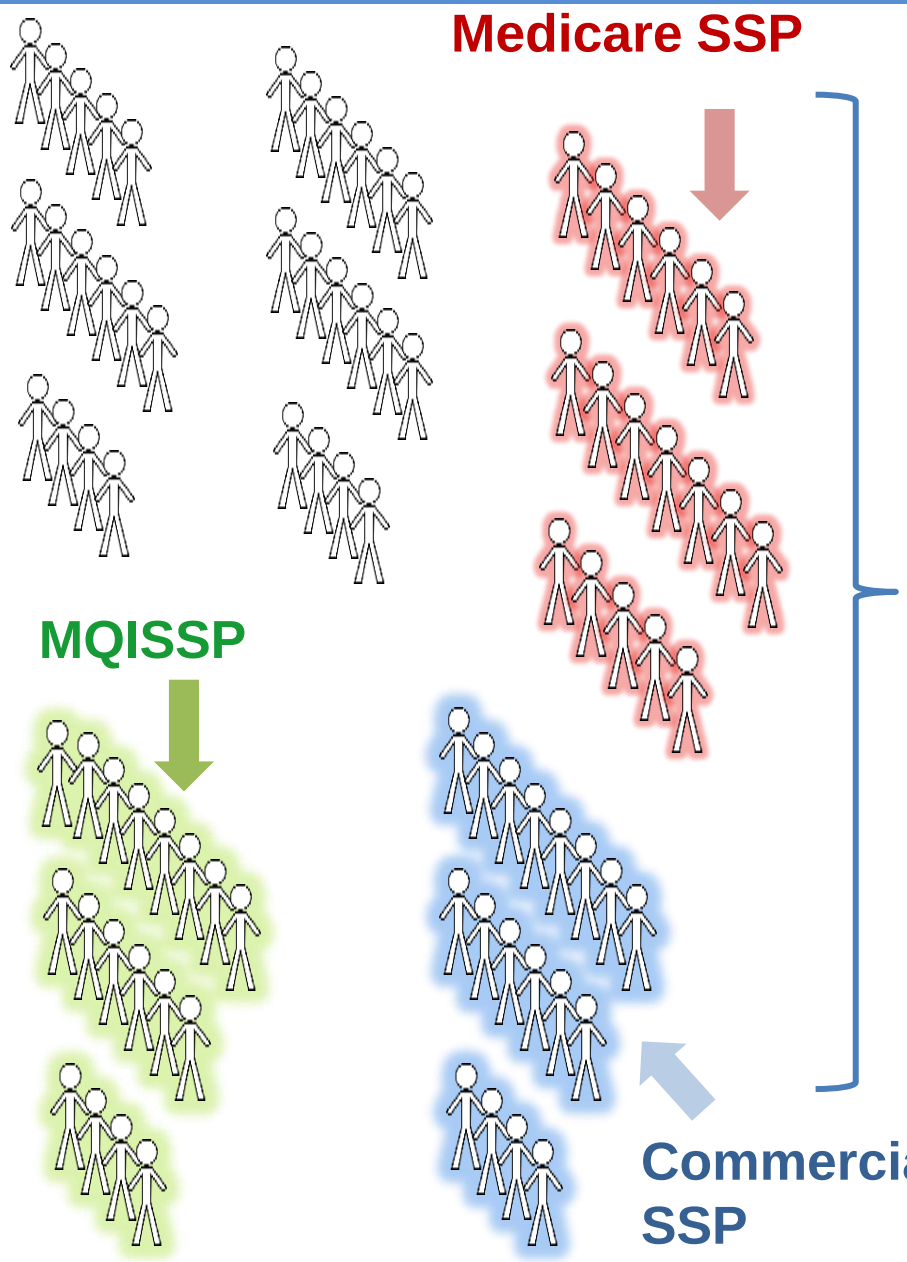
Connecticut has many Advanced Networks

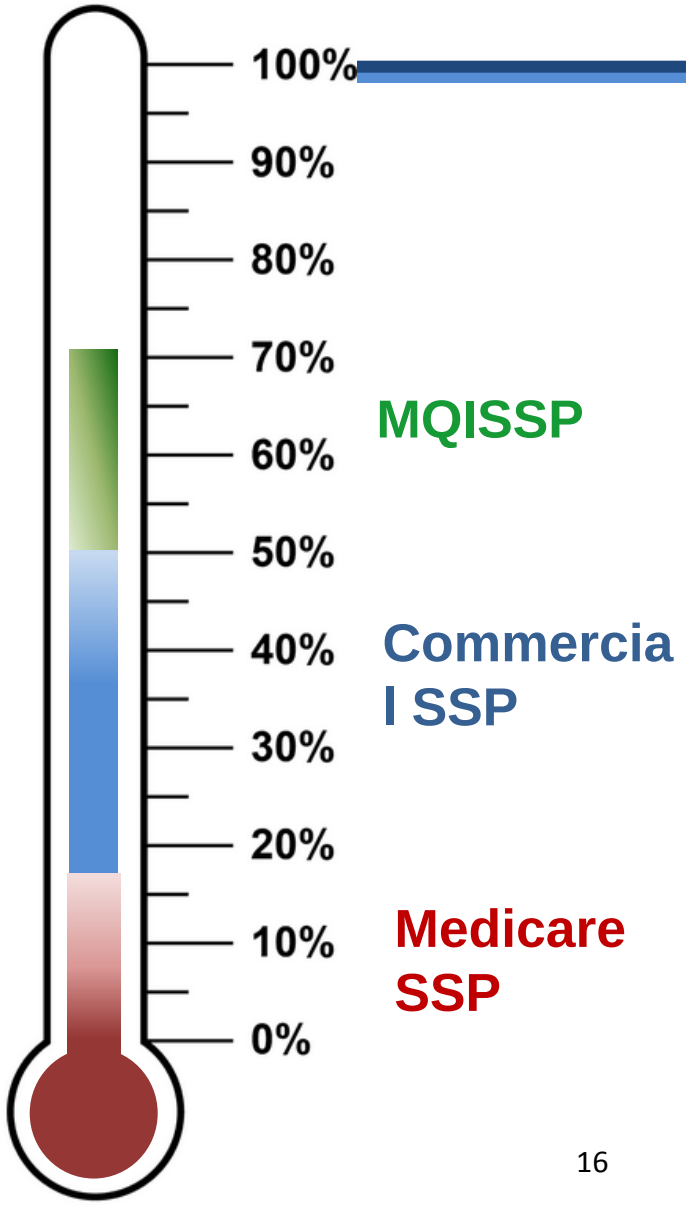


Expanding the reach of Value-Based Payment



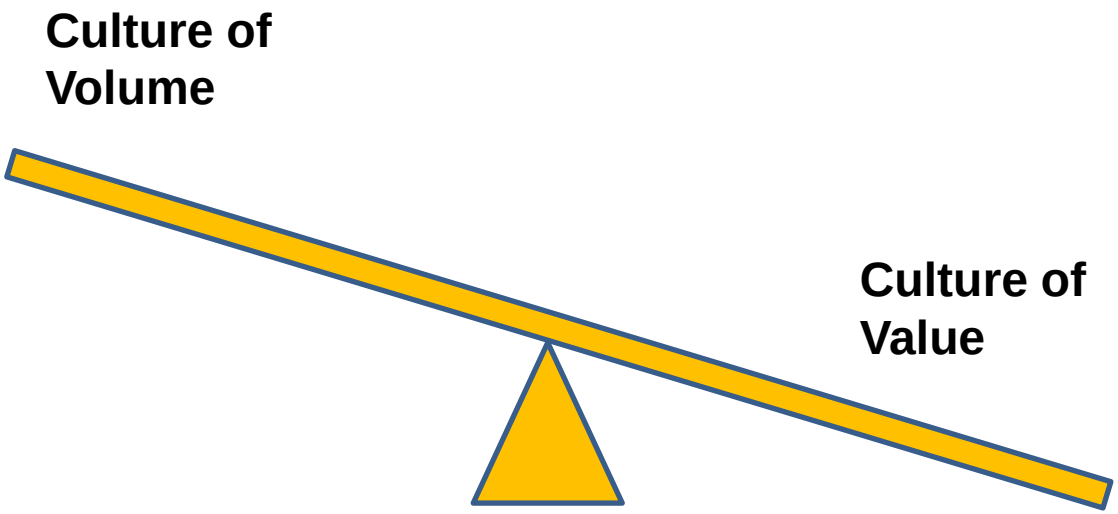
Reaching the tipping point

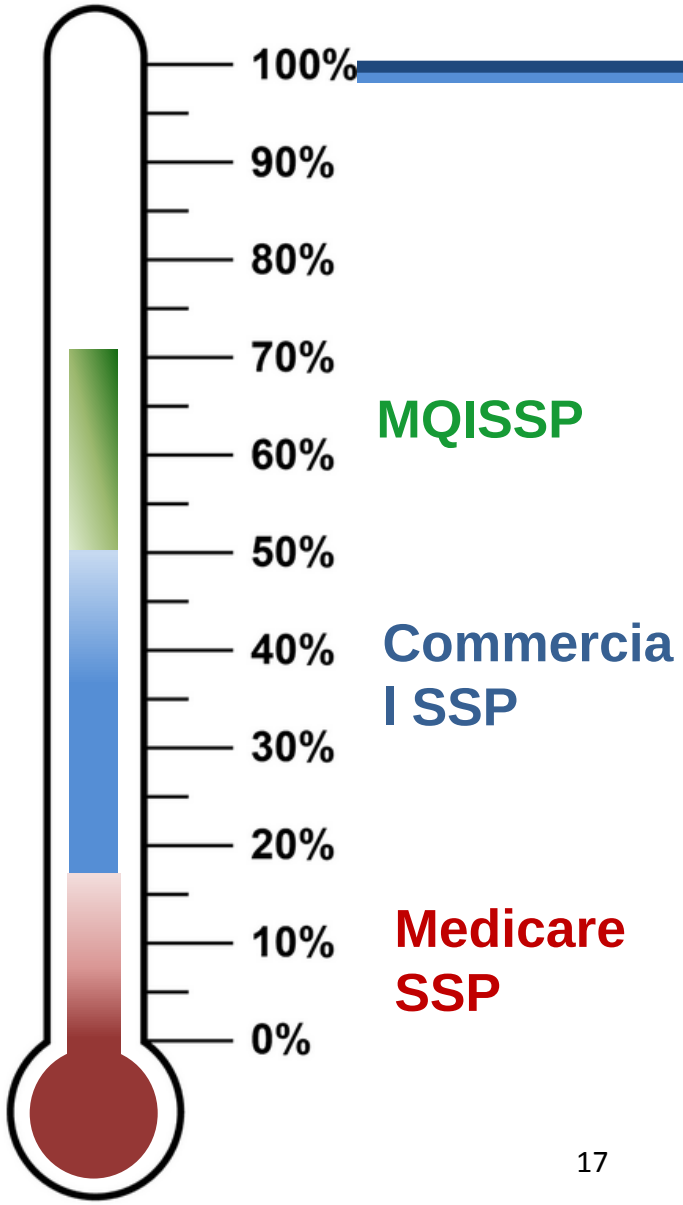




% of consumers in an Advanced Network in value-based payment arrangement

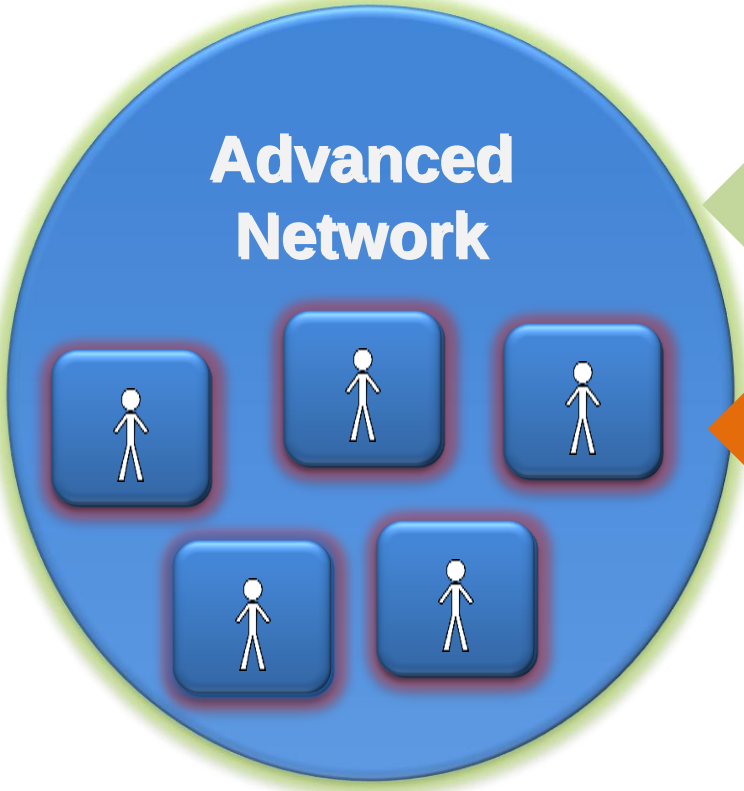
Reaching the tipping point





% of consumers in an Advanced Network in value-based payment arrangement

Resources aligned to support transformation



Community & Clinical Integration Program (CCIP)

Awards & technical assistance to support Advanced Networks in enhancing their capabilities across the network

Advanced Medical Home (AMH) Program

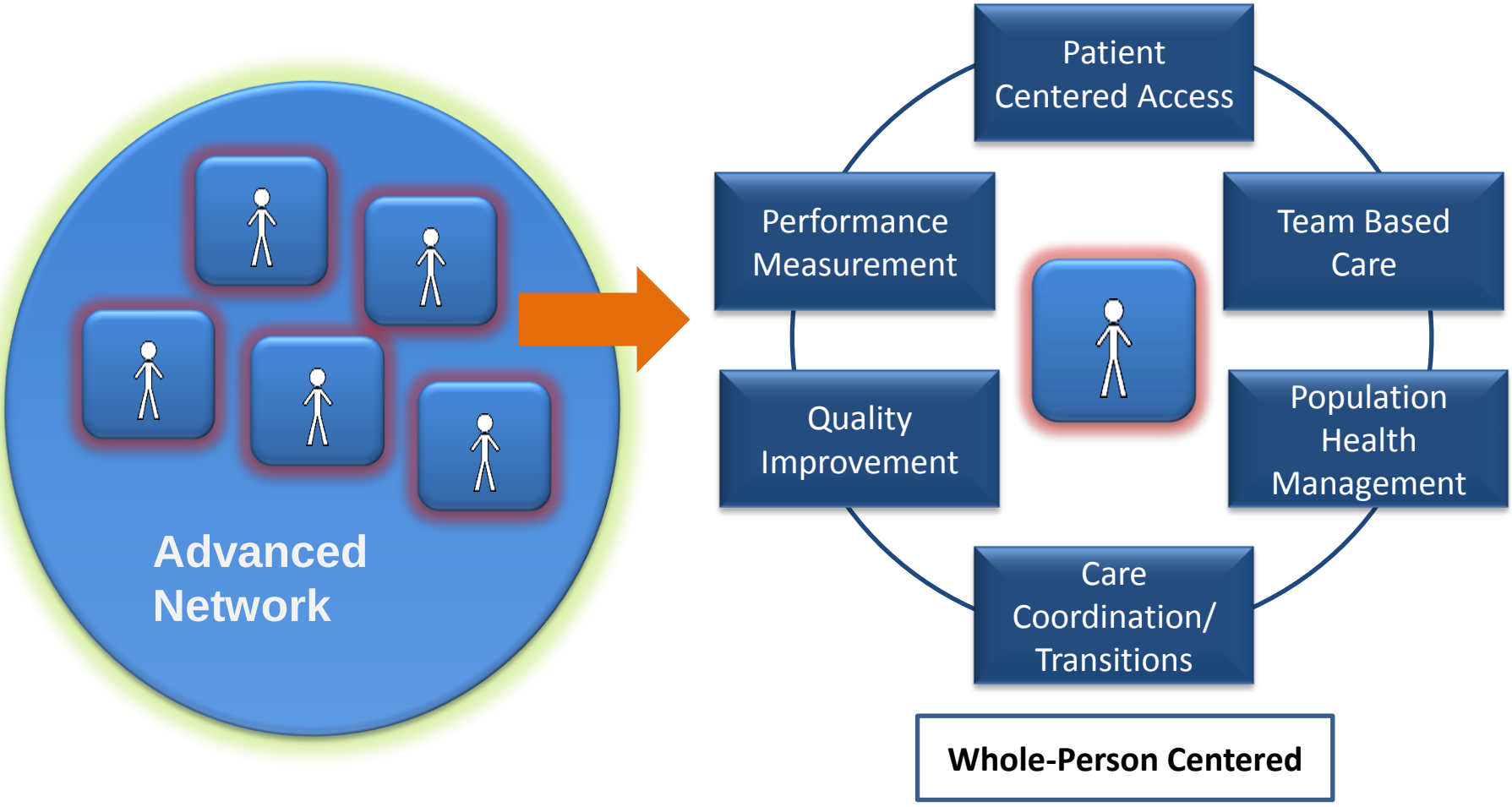
Support for individual primary care practices to achieve Patient Centered Medical Home NCQA 2014 recognition and additional requirements

Improving care for all populations
Using population health strategies

Improving capabilities of practices in Advanced Networks

Advanced Medical Home Program

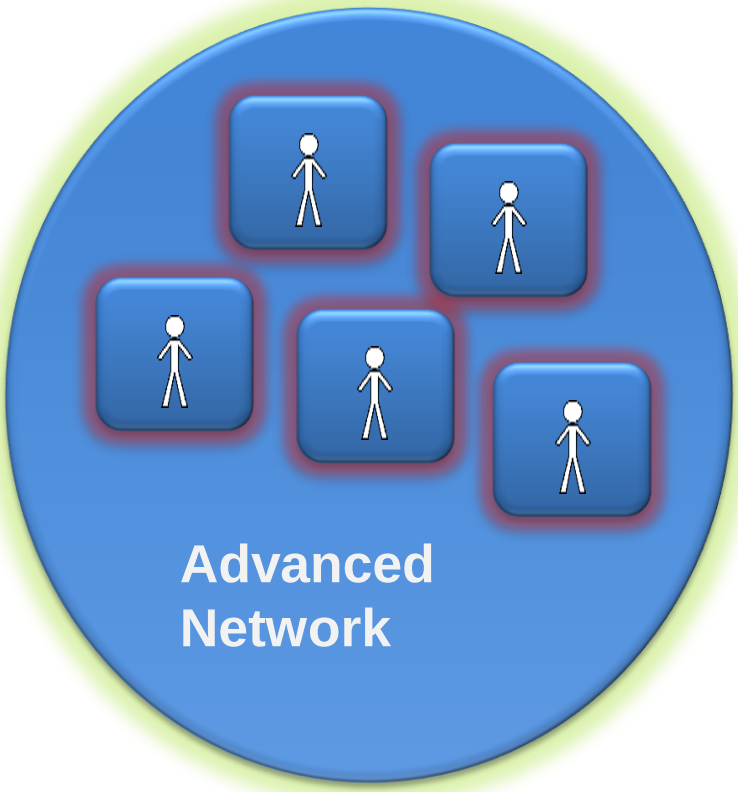
Webinars, peer learning & on-site support for individual primary care practices to achieve Patient Centered Medical Home NCQA 2014 and more



Improving capabilities of Advanced Networks

Community & Clinical Integration Program

Awards & technical assistance to support Advanced Networks in enhancing their capabilities in the following areas:



Supporting Individuals with Complex Needs

Comprehensive care team, Community Health Worker , Community linkages

Reducing Health Equity Gaps

Analyze gaps & implement custom intervention ✚ CHW & culturally tuned materials

Integrating Behavioral Health

Network wide screening, assessment, treatment/referral, coordination, & follow-up

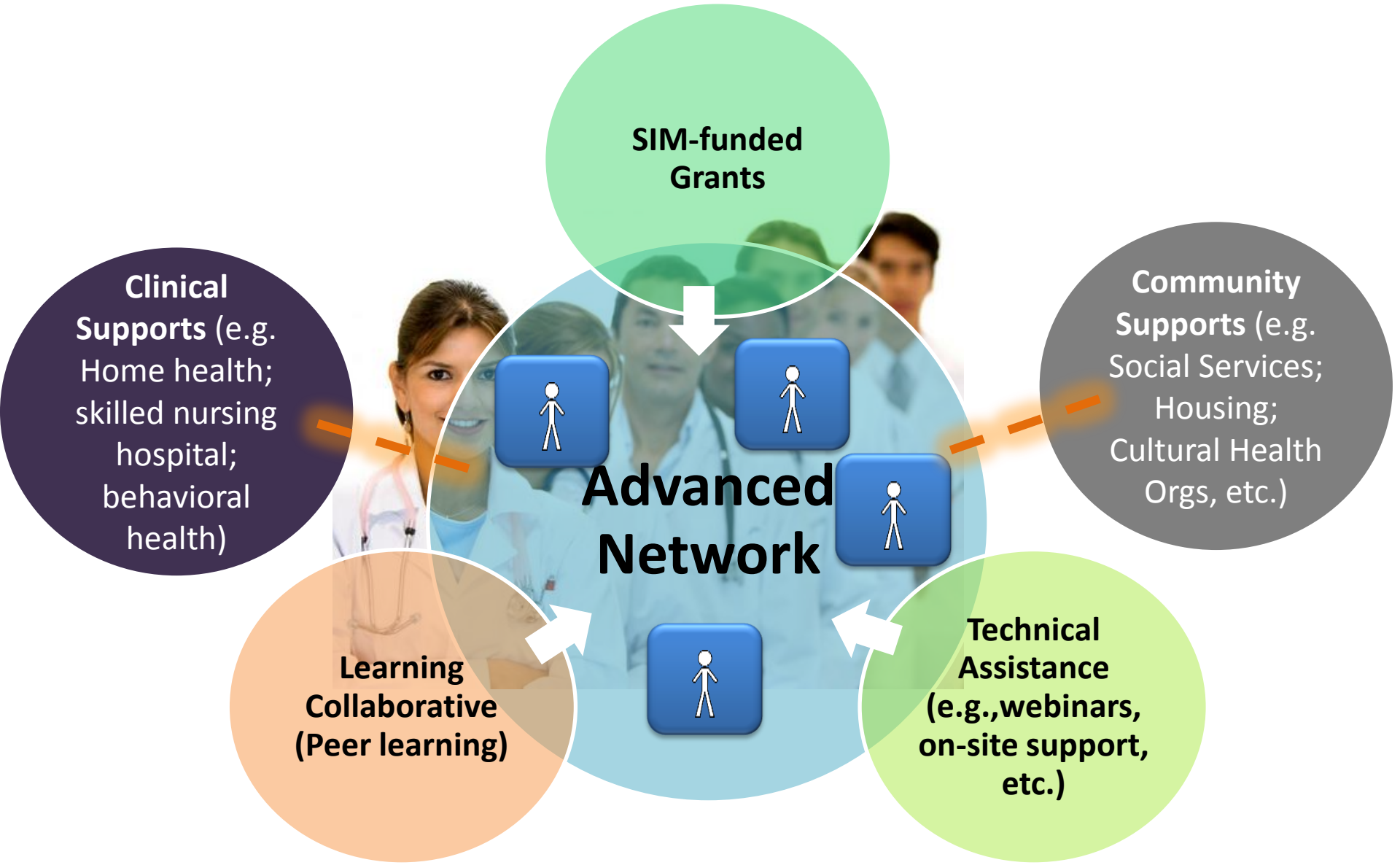
Community Health Collaboratives

Comprehensive Medication Management

E-Consults

Oral health

How will CCIP support provider entities?



What will provider entities be required to do under CCIP?

- Under CCIP, participating entities will receive technical assistance in developing new capabilities for improving care, especially for at-risk populations.
- They will be required to better engage patients as partners in their own healthcare and to help build coordinated systems that support patients' clinical and non-clinical needs.
- It is especially important to note that the CCIP programs will focus on improving healthcare outcomes for all patients regardless of their insurance carrier (i.e., payer).

Which providers will participate in CCIP?

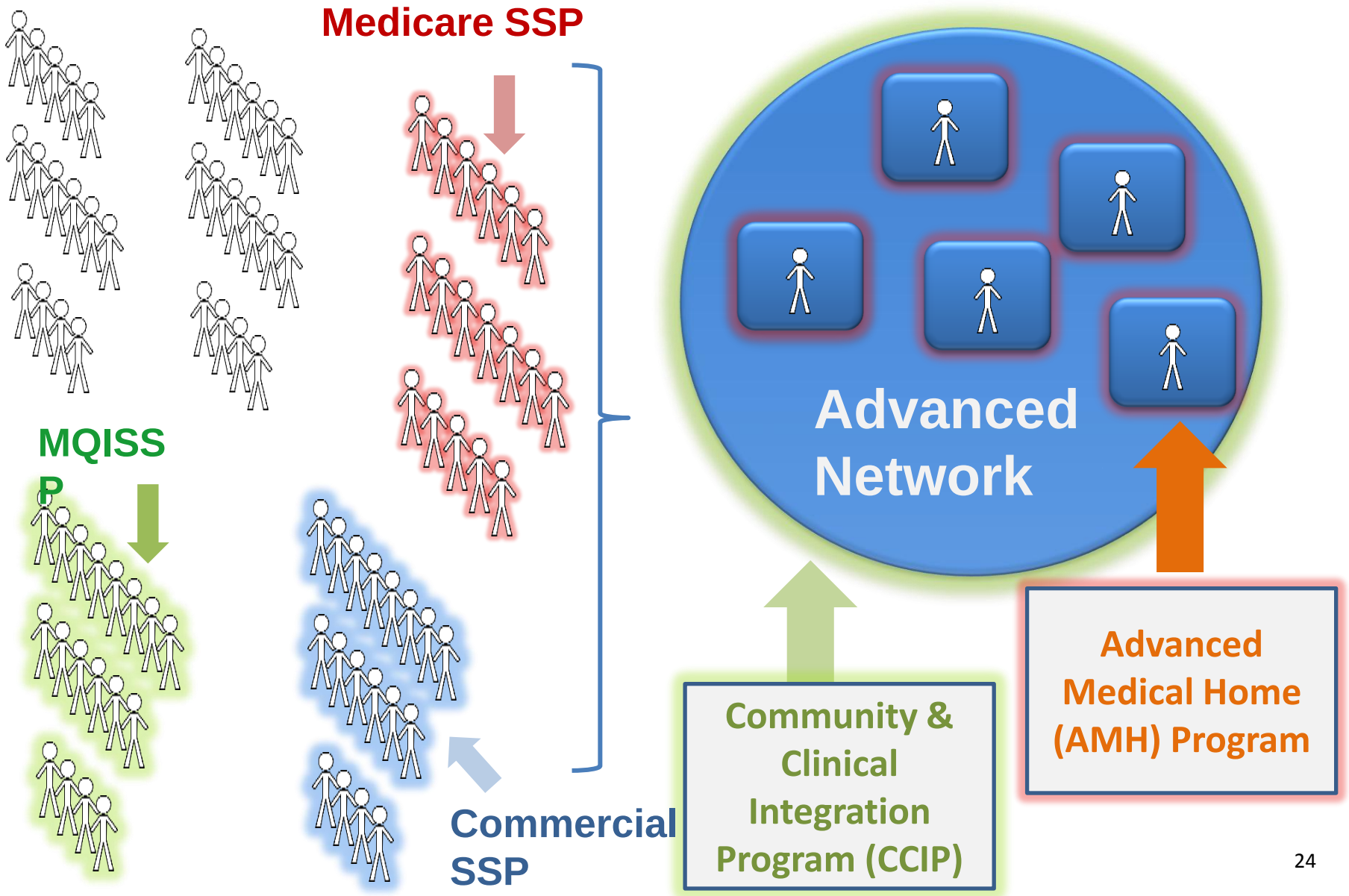
- Advanced Networks and Federally Qualified Health Centers (FQHCs) selected to participate in the Medicaid Quality Improvement and Shared Savings Program (MQISSP) will be required to participate in CCIP.
- Pairing CCIP with MQISSP aligns resources to support a shift in favor of efficiency, prevention, and continuous quality improvement. This aligns with the interests of providers that are expanding their participation in value-based payment models. These providers have strong incentives to perform well on quality measures and improve the overall efficiency and effectiveness of patient care processes.

Payment reform to value based payments to reward higher quality & reduced cost

+

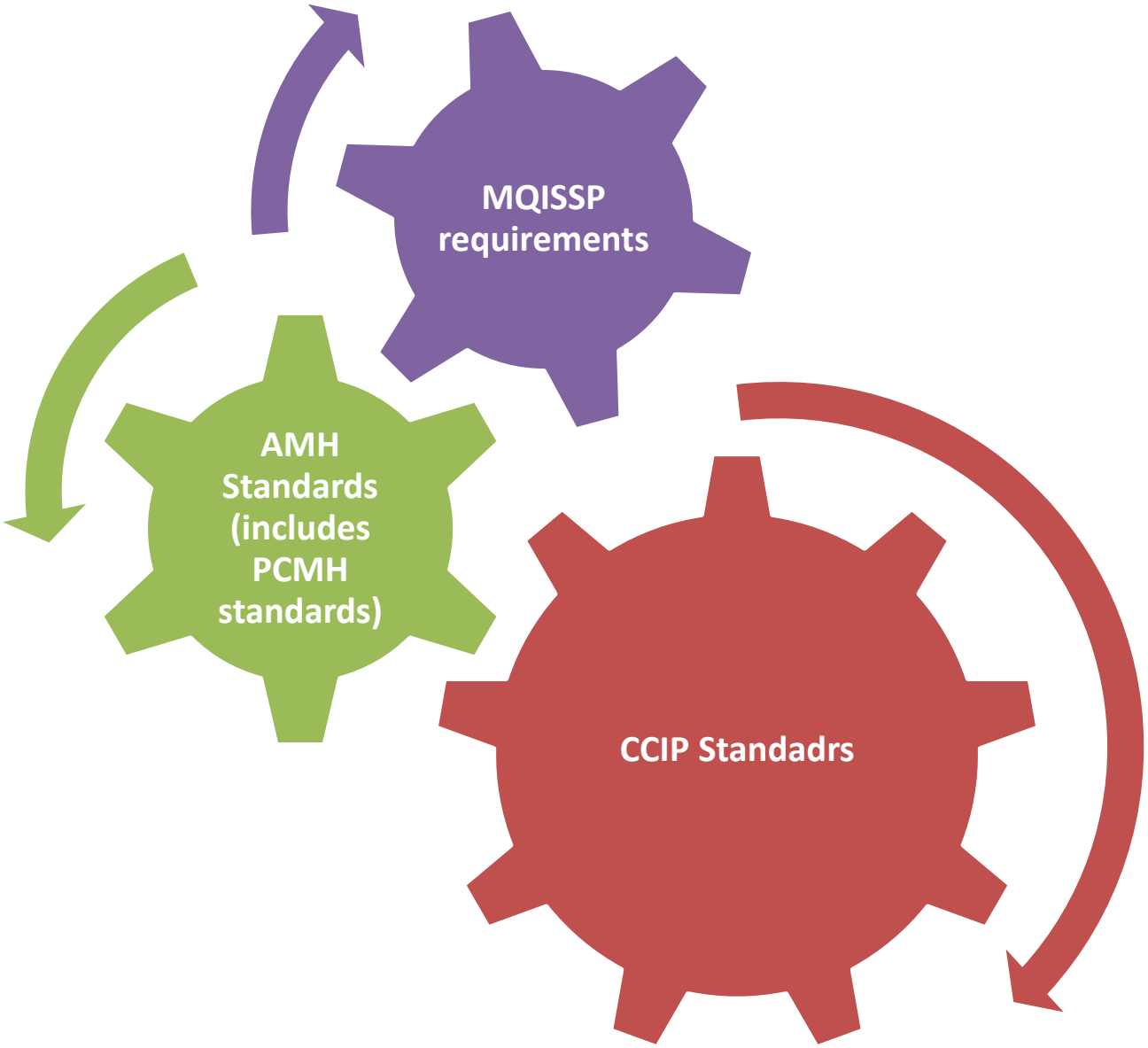
Delivery system reform to support higher quality through care transformation at the practice and network levels

Putting it all together



Aligning with current initiatives

CCIP aims to leverage and align with current and planned care coordination activities, including the AMH program, and the care coordination activities required under MQISSP.



CCIP Standards

CCIP Standards

Core Standards

Supporting Individuals with Complex Needs

Comprehensive care team, Community Health Worker , Community linkages

Reducing Health Equity Gaps

Analyze gaps & implement custom intervention ✚ CHW & culturally tuned materials

Integrating Behavioral Health

Network wide screening tools, assessment, linkage, follow-up

Community Health Collaboratives

Elective Standards

Comprehensive Medication Management

E-Consults

Oral health

Design Programs: Comprehensive Care Management

Complex Patient Intervention Objective

Intended to provide intensive care management to individuals who have multiple complex medical conditions, multiple detrimental social determinants of health, or a combination of both that contribute to preventable service utilization and poorer overall healthcare management that negatively impacts the individual's overall health status.

Intervention Highlights

- Complex individuals will be **identified** through risk stratification that considers **clinical**, **behavioral**, and **social** risk factors
- Individuals with complex needs will be connected to a **comprehensive care team** to receive more intensive care management support
- The care team will include a **Community Health Worker** to provide community focused care **coordination with social services** and to provide **culturally and linguistically aligned self-care management education**. Additionally there will be a **case manager**, a **clinically focused care coordinator,** and a **care team manager**
- The care team will also have access to a **licensed behavioral health specialist** to address behavioral health needs of complex individuals

Design Programs: Comprehensive Care Management

Intervention Highlights

- The network will conduct a **root cause analysis** among their complex patient population to identify and implement additional interventions to the care team and/or additional care team members that may be beneficial
- The care team will perform a **person-centered needs assessment** that will inform a **person-centered care coordination plan** to support the individual to reach his/her clinical, social, and behavioral treatment goals. This plan will be incorporated into the primary care plan and coordinated through the primary care providers and expanded community care team.
- The individual will be **transitioned to self-directed care management** when the care team and individual feels ready
- There will be processes in place to **monitor transitioned patients** for the need to reconnect post-transition

Design Programs: Equity Gaps

Equity Gap Intervention Objective

Identify and provide culturally and linguistically appropriate support to sub-populations, defined by a large race and ethnic backgrounds, that in aggregate are experiencing poorer health outcomes as compared to other sub-populations. The goal of this programs is to identify individuals within the sub-population who would benefit from more culturally and linguistically appropriate care.

Intervention Highlights

- The CCIP equity gap program will include two elements – 1) standards on how to do **health equity continuous quality improvement**; and 2) standards for an **intervention to address identified equity gaps**
- The **continuous quality improvement** standards provide guidance on how to routinely capture and analyze data to **identify health care disparities at a population level**
- The intervention standards provide guidance on how to **standardize certain care processes to make them more culturally and linguistically appropriate** and offering the **support of a Community Health Worker to those who will benefit** from more culturally supportive care

Design Programs: Equity Gaps

Intervention Highlights

- The CHW will be trained to offer culturally and linguistically appropriate **education specific to the patient's clinical area of need** (e.g.; diabetes) and on **better self-care management skills**.
- The CHW will collaborate with the patient to **develop a person-centered self-care management plan** that reflects the patients cultural needs, personal preferences, values, strengths and **readiness to change.**
- The networks will monitor the equity gap intervention for **effectiveness** through monitoring **quality** and **patient experience** metric

Design Programs: Behavioral Health Integration

Behavioral Health Integration Intervention Objective

The Behavioral Health Integration standards are intended to improve the ability of primary care practices to identify and treat behavioral health needs either within the primary care setting or to make, confirm, and close the communication loop on a referral when necessary

Intervention Highlights

- The networks will incorporate the use of a **screening tool** to screen all patients for **mental health, substance abuse, and trauma needs**
- When a behavioral health **need is identified** the primary care providers will determine in collaboration with the patient if they want/can be treated in the primary care setting or would prefer/need a referral
- Networks will **develop an MOU with at least one behavioral health provider** to support the facilitation and accountability for the referral process
- Processes and protocols will be developed in partnership with behavioral health providers to facilitate **referral tracking, follow up, and ensuring that the behavioral health care plan is shared with primary care** when a referral is made
- Provision of appropriate **behavioral health training** on **promotion**, **detection**, **diagnosis**, and **referral for treatment** for primary care practice

4. Review of Key Public Comments

Integration and coordination of CCIP, PCMH, and existing programs

Comment Summary

Commenters believe that there should be more clarification around the integration of CCIP with existing care coordination efforts, in particular with the PCMH program, to ensure that unnecessary duplication of efforts does not add an extra layer of burden on providers. Commenter believes that the CCIP and the SIM Advanced Medical Home Vanguard program are unintentionally undermining the PCMH program, in particular through the Community Health Teams outlined in the report.

PMO Disposition

- CCIP establishes a minimum standard of capabilities among ANs/FQHCs, including care coordination support for complex populations. It is not intended to supplant activities that are already in place. The transformation vendor will conduct a gap analysis at the start in order to determine which standards or elements have already been met and which standards or elements have not been met. The transformation support will focus on those areas that have not been met. In this way, the CCIP should not disrupt existing care coordination efforts that a provider may have in place as a PCMH.

Actions Taken

- PMO clarified at multiple points in the report narrative and standards the role of the transformation vendor in assisting with this capabilities assessment and determining where focus should be. Care plans and additions to care team are intended to be components/extensions of existing care coordination teams, not to overlap with them.

4. Review of Key Public Comments

Community Health Board Structure

Comment Summary

Commenters request more clarity around what support it will receive and its structure so that it can be effective. Commenters specifically requested more information around how local entities would interact with the Board and how they can integrate with efforts underway by DPH and local health departments as well as the ACA-instituted non-profit hospital Community Health Needs Assessments.

PMO Disposition

- The report was intended to introduce the concept of a multi-stakeholder board or collaborative responsible for developing consensus protocols. This concept will be further developed in collaboration with DPH and other partners in the coming months. Although the report introduced the concept, it was not intended to create structures that are duplicative.

Actions Taken

- PMO clarified in the report that similar efforts are already underway in some areas. CCIP participating providers are responsible for participating in, rather than organizing these efforts. Current plan is to require the transformation vendor to organize and facilitate these efforts. These standards were removed from the list of "core" standards and will be placed in a separate section when revisions are complete.

4. Review of Key Public Comments

*Patients with Complex Conditions Definition **

Comment Summary

Commenter recommends that the report clearly describe and outline the target population and complex patient definition and suggests the Institute of Medicine's definition of serious and complex medical conditions. Other commenters shared concern about the definition in terms of targeting the right patients in Connecticut.

PMO Disposition

- With so many different public health programs focusing on variations of populations in need, terminology around the design of programs can get confusing. The PMO recommended that the PTTF consider the IOM definition as an option that might be nationally recognized.

Actions Taken

- After reviewing the IOM definition, the PTTF concluded that the definition was not whole-person centered enough and did not adequately capture the range of patients with non-clinical needs for the CCIP. The PTTF made additional changes to its original definition and adopted it for the report. Issues remains as to whether this definition should exclude patients with acute rather than chronic needs.

* See appendix for IOM complex population definition and proposed complex population definition.

4. Review of Key Public Comments

Standards Flexibility

Comment Summary

Commenters believe that all standards should be optional and that participation in the program should be voluntary at the discretion of MQISSP providers who seek out additional technical assistance.

PMO Disposition

- The PTTF considered this issue at several points throughout the process and retained the view that core standards should be required. They noted flexibility is built into standards, which typically do not prescribe how the standard must be met. The application of the standards may also allow for local variations in need, capabilities, and resources.

Actions Taken

- The PTTF reconsidered this issue at its meeting on September 29th. The PTTF agreed with the need for flexibility in implementation but asserted that basic minimum standards to raise the quality of care for patients in all three focus populations are necessary and should be required. The PTTF and PMO will work with the transformation support vendor to ensure that there is sufficient flexibility in the application of the standards to support success.

4. Additional Key Changes

Additional edits to the report were suggested through the PTTF and incorporated into the report

Whole-person centered language

- Report was scrubbed of terminology perceived as demeaning to individuals with chronic conditions (e.g., “super utilizer”)
- Report edited for clarity and unnecessary technical language reduced to be more consumer friendly and readable
- Report focused on engaging patients as partners in their healthcare throughout

Definitions

- Report updated several definitions throughout the report including those for peer support specialist, person-centered, person-centered assessment, and person-centered care coordination plan
- New definitions focus on more person-centeredness, engaging patients as partners, and integration of interventions with existing programs

Comprehensive Care Management

- First draft of report created the impression of standalone CCIP programs, which might compete or conflict with existing programs, rather than standards
- The proposed “Community Health Teams” appeared to be stand-alone care teams separate from the primary care team
- Report was edited to emphasize comprehensive care management as a function performed by the primary care team with additional members added to the team based on individual needs and preferences. Now “comprehensive care team.”
- Report now emphasizes primary care/medical home care plan as the foundation, with additional elements to reflect results of person centered assessment.

4. Additional Key Changes

Additional edits to the report were suggested through the PTTF and incorporated into the report

Comprehensive Medication Management

- Medication Therapy Management (MTM) standards were changed to Comprehensive Medication Management (CMM) to be more in line with current practices in Connecticut and accepted terminology
- Additional clarifications were made as well as suggestions for credentialing according to best practices and input provided to the PTTF

Care Transitions

- Stand-alone care transition standards were deemed to be too hospital-centric and folded into the existing standards
- Community Health Collaboratives (formerly "Boards") and the transformation vendor will assist community stakeholders, including Advanced Networks and FQHCs, with developing more effective consensus protocols for community linkages, coordination, and transitions of care

5. Open Issues

Integration with Existing DSS and DPH Initiatives

Issue for Implementation

Additional work is needed with DPH and DSS to ensure integration and coordination with existing initiatives including:

1. Medical and behavioral health ASO intensive care management
2. CMMI stipulations around duplicate support for TCPI awards and SIM
3. SIM funded population health planning processes and goals

Next steps

- The PMO is engaged with DSS on issues related to complex care management and its relationship to the federated medical and behavioral ASO ICM models
- The PMO has reached out to the TCPI awardees, DSS and CMMI to begin to examine how the TCPI funded initiatives relate to SIM funded initiatives, how best to address areas of potential duplication, and how to maximize this opportunity to the maximum benefit of both programs and their participants
- The PMO is engaged with DPH on issues related to the process for developing consensus protocols by which clinical providers coordinate with community resources , including in relation to care transitions, and other ways to maximize the use of population health strategies.

5. Open Issues

Financial support for transformation

Issue for Implementation

Numerous commenters identified the importance of funding to offset the investments require to meet CCIP standards

Next steps

- Assess the extent transformation funding will be needed for all MQISSP recipients in light of the TCPI/PTN awards
- Assess opportunities to re-allocate budgeted funds within the SIM grant to restore funding for innovation awards (i.e., transformation grants).

5. Open Issues

Health Information Technology

Issue for Implementation

- Many of the capabilities promoted in CCIP depend on health information technology.
- The SIM model test grant proposes funding a menu of technology tools that could serve as enablers to participating Advanced Networks and FQHCs, e.g., technology to support the deployment of electronic admission, discharge, and transfer alerts.
- Other technologies will be required, funding for which will be the responsibility of the networks and which will likely require ongoing development and associated investments.

Next steps

- The SIM PMO, DSS and the UConn HIT technology team will work with the HIT Council and PTTF to further define those program needs where SIM funded technology would be most appropriate.

- The PMO will also consider commitments to participate in such technology solutions that might be required as a condition of participation in CCIP.

5. Open Issues

Transformation Vendor Role

Issue for Implementation

Current roles envisioned for the transformation vendor:

1. Assist the network in conducting a needs assessment to confirm that CCIP core areas of assistance align with network needs;
2. Undertake a gap analysis to inform an implementation plan for the CCIP assistance. If the standards do not align with network needs, the vendor will work with the AN/FQHC to determine how to adapt the core interventions and/or include the elective interventions to better meet their network's population needs;
3. Ensure that participating providers are familiar with the science of change management; and
4. Lead the effort to put in place the Community Health Collaboratives.

Remaining Questions

- The PMO is tasked with identifying which vendors will be appropriate for the roles above, how many vendors will be needed, and how they will interface with participating providers and the PMO

Questions & Discussion

Appendix: Institute of Medicine Definition of Complex

The Institute of Medicine states that serious and complex medical conditions should reflect the characteristics of the management of the condition rather than some inherent biological complexity, such as:

- Conditions that are life threatening.
- Conditions that cause serious disability without necessarily being life threatening.
- Conditions that cause significant pain or discomfort that can cause serious interruptions to life activities.
- Conditions that require major commitments of time and effort from caregivers for a substantial period of time.
- Conditions that may require frequent monitoring.
- Conditions that predict or are associated with severe consequences.
- Conditions associated with negative consequences for someone else.
- Conditions that affect multiple organ systems.
- Conditions that require management to "tight" physiological parameters.
- Conditions whose treatment carries a risk of serious complications.
- Conditions requiring adjustment in a "nonmedical environment."

Appendix: Existing Definitions in report

- **Complex Patients:** Individuals who have or are at risk for multiple complex health conditions, multiple detrimental social determinants of health, or a combination of both that contribute to preventable service utilization and poorer overall healthcare management that negatively impacts the individual's overall health status.

- **Patients Experiencing Equity Gaps**: Individuals belonging to a sub-population experiencing poorer health outcomes in a specific clinical area (e.g., diabetes). For the first wave of CCIP, the intervention will focus on sub-populations defined by large race and ethnic populations, specifically White, Black, and Latino. The intervention will further focus on diabetes, hypertension, and asthma, as these conditions are among the State's priority areas in the Department of Public Health's Chronic Disease Prevention and Health Promotion Plan and are target areas for improvement in the SIM Provisional Quality Measure set. Additional sub-populations defined by race, ethnicity, and sexual orientation/gender identity who are experiencing equity gaps in Connecticut will be identified as the program continues.

- **Patients with Unidentified Behavioral Health Needs**: Any individual with an unidentified behavioral health need including mental health, substance abuse, or history of trauma.

Appendix: Core Intervention Standards

7. Core Standards

The three core interventions focus on populations who have demonstrated health needs that align with SIM goals, align with CT population health goals, and that provide both evidence-based standards for improvement with flexibility in implementation. Their objectives are as follows:

Individuals with complex health needs

- Intended to provide intensive care management to individuals who have multiple complex medical conditions, multiple detrimental social determinants of health, or a combination of both that contribute to preventable service utilization and poorer overall healthcare management that negatively impacts the individual's overall health status

Individuals experiencing health equity gaps

- Identify and provide culturally and linguistically appropriate support to sub-populations, defined by a large race and ethnic backgrounds, that in aggregate are experiencing poorer health outcomes as compared to other sub-populations. The goal of this program is to identify individuals within the sub-population who would benefit from more culturally and linguistically appropriate care

Individuals with unmet behavioral health needs

- Intended to improve the ability of primary care practices to identify and treat behavioral health needs within the primary care setting, to ensure referral and linkage for those who require behavioral health specialty care, and follow-up

Design Programs: Complex Individuals

Complex Patient Intervention Objective

Intended to provide intensive care management to individuals who have multiple complex medical conditions, multiple detrimental social determinants of health, or a combination of both that contribute to preventable service utilization and poorer overall healthcare management that negatively impacts the individual's overall health status.

Intervention Highlights

- Complex individuals will be **identified** through risk stratification that considers **clinical**, **behavioral**, and **social** risk factors
- Individuals with complex needs will be connected to a **Comprehensive Care Team (CCT)** to receive more intensive care management support
- The CCT will include a **Community Health Worker** to provide community focused care **coordination with social services** and to provide **culturally and linguistically aligned self-care management education**. Additionally there will be a **case manager**, a **clinically focused care coordinator,** and a **CCT manager**
- The CCT will also have access to a **licensed behavioral health specialist** to address behavioral health needs of complex individuals

Design Programs: Complex Individuals

Intervention Highlights

- The network will conduct a **root cause analysis** among their complex patient population to identify and implement additional interventions to the CCT and/or additional CCT team members that may be beneficial
- The CCT will perform a **person-centered needs assessment** that will inform a **person-centered care coordination plan** to support the individual to reach his/her clinical, social, and behavioral treatment goals. This plan will be incorporated into the primary care plan and coordinated through the primary care providers and expanded community care team.
- The individual will be **transitioned to self-directed care management** when the CCT and individual feels ready
- There will be processes in place to **monitor transitioned patients** for the need to reconnect post-transition

Design Programs: Equity Gaps

Equity Gap Intervention Objective

Identify and provide culturally and linguistically appropriate support to sub-populations, defined by a large race and ethnic backgrounds, that in aggregate are experiencing poorer health outcomes as compared to other sub-populations. The goal of this programs is to identify individuals within the sub-population who would benefit from more culturally and linguistically appropriate care.

Intervention Highlights

- The CCIP equity gap program will include two elements – 1) standards on how to do **health equity continuous quality improvement**; and 2) standards for an **intervention to address identified equity gaps**
- The **continuous quality improvement** standards provide guidance on how to routinely capture and analyze data to **identify health care disparities at a population level**
- The intervention standards provide guidance on how to **standardize certain care processes to make them more culturally and linguistically appropriate** and offering the **support of a Community Health Worker to those who will benefit** from more culturally supportive care

Design Programs: Equity Gaps

Intervention Highlights

- The CHW will be trained to offer culturally and linguistically appropriate **education specific to the patient's clinical area of need** (e.g.; diabetes) and on **better self-care management skills**.
- The CHW will collaborate with the patient to **develop a person-centered self-care management plan** that reflects the patients cultural needs, personal preferences, values, strengths and **readiness to change.**
- The networks will monitor the equity gap intervention for **effectiveness** through monitoring **quality** and **patient experience** metric

Design Programs: Behavioral Health Integration

Behavioral Health Integration Intervention Objective

The Behavioral Health Integration standards are intended to improve the ability of primary care practices to identify and treat behavioral health needs either within the primary care setting or to make, confirm, and close the communication loop on a referral when necessary

Intervention Highlights

- The networks will incorporate the use of a **screening tool** to screen all patients for **mental health, substance abuse, and trauma needs**
- When a behavioral health **need is identified** the primary care providers will determine in collaboration with the patient if they want/can be treated in the primary care setting or would prefer/need a referral
- Networks will **develop an MOU with at least one behavioral health provider** to support the facilitation and accountability for the referral process
- Processes and protocols will be developed in partnership with behavioral health providers to facilitate **referral tracking, follow up, and ensuring that the behavioral health care plan is shared with primary care** when a referral is made
- Provision of appropriate **behavioral health training** on **promotion**, **detection**, **diagnosis**, and **referral for treatment** for primary care practice

Appendix: Elective Intervention Standards

7. Elective Standards

The elective standards represent best practices in areas that complement the core standards, but that are not limited to patients within the focus populations of CCIP. The objectives of each intervention are as follows:

Comprehensive Medication Management

- Intended to assure safe and appropriate medication use by engaging patients, caregivers/family members, and health care providers improve health outcomes related to the use of medications.

Electronic Consults

- Intended to improve timely access to specialists, improve PCP and specialist communication, and reduce downstream costs through avoiding unnecessary in-person specialist consultations. E-consults will facilitate this through providing primary care providers the means to seamlessly consult electronically with specialists prior to referring a patient for a face to face consult.

Oral Health

- Improve dental and overall health for all populations by providing oral health prevention in the primary care setting and forming stronger linkages between primary care and oral health providers. It is well acknowledged that there is a an oral/systemic link. An individual's oral health can impact their overall health and vice versa, in particular when individuals have chronic conditions like diabetes.

Design Programs: Oral Health Integration

Oral Health Integration Intervention Objective

Improve dental and overall health for all populations through providing oral health prevention in the primary care setting and forming stronger linkages between primary care and oral health providers. It is well acknowledged that there is a an oral/systemic link. An individual's oral health can impact their overall health and vice versa, in particular when individuals have chronic conditions like diabetes.

Intervention Highlights

- The networks standardize care processes to **routinely do an oral health screening and exam**
- The appropriate primary care providers are trained to **provide preventive care** within the primary care setting
- The practice will develop resources and processes/protocols **to make**, **manage**, and **close out dental referrals** with a **preferred dental network** for individuals who do not have a regular source of dental care
- The network and the preferred dental network establish **technology to support communication** of the relevant care information between primary care and dental providers

Design Programs: E-consults

E-consults Intervention Objectives:

Improve timely access to specialists, improve PCP and specialist communication, and reduce downstream costs through avoiding unnecessary in-person specialist consultations. E-consults will facilitate this through providing primary care providers the means to seamlessly consult electronically with specialists prior to referring a patient for a face to face consult.

Intervention Highlights

- The networks will **elect one specialty area to do e-consults** – common areas already in practice in Connecticut include cardiology and dermatology
- **A specialist practice/providers will be identified** either within or outside the network, depending on the Advanced Network/FQHCs physician make up, with which to **establish e-consult protocols**
- The designated specialists reviewing e-consults will determine 1) if **a face to face is needed**; 2) if **more information on the patient is needed** before a determination about a face to face consult can be made; or, 3) A **face to face consult is not needed** and a **consult note is provided** from the specialist to the primary care provider on how to care for the patient in the primary care setting
- The networks will have to establish a **reimbursement mechanism** for e-consults

Design Programs: Comprehensive Medication Management

Medication Therapy Management Objective

CMM is a system-level, person-centered process of care provided by pharmacists to optimize the complete drug therapy regimen for a patient's given medical and socio-economic condition. This intervention will be an elective CCIP capability for patients with complex therapeutic needs who would benefit from a comprehensive personalized medication management plan. This intervention is designed assure safe and appropriate medication use by engaging patients, caregivers/family members, and health care providers improve health outcomes related to the use of medications.

Intervention Highlights

- The networks develop processes to **assess the risk of a patient's pharmacy regimen**.
- The networks **design a pharmacist integration model** that aligns with their needs and capacity
- The pharmacist **integrates with the care team** and provides CMM services
- The **medication action plan is person-centered** and addresses medical issues such as appropriateness, efficacy, and safety as well as socio-economic issues such as affordability, cultural traditions and lifestyle
- CMM is a fluid process that **includes follow-up and subsequent touch points** with the patient
- The medication **action plans becomes part of the primary care plan** and becomes part of the care conferences regarding patient progress

Appendix: Community Health Collaboratives

7. Community Health Collaboratives

Establish consensus protocols to better standardize the linkage to and provision of socio-economic services related to the health needs of patients and care transition coordination among community participants. This system of shared decision-making helps further the integration of community services with healthcare services and may prepare communities for the next stage of shared accountability under population health related SIM initiatives. The community consensus guidelines will impact patients with complex conditions and health equity gaps, who are disproportionately in need of better coordination with community resources.

Design Programs: Community Consensus & Linkages

Shared Governance Objective

Development of Advanced Network and FQHC linkages to community resources is a key component of the CCIP. Because many of the needed community resource providers are resource, capacity, and geographically constrained the PTTF is recommending convening community stakeholders to establish local Community Health Collaboratives to better integrate social services. The structure will be developed by the technical assistance vendor in the service areas where there are Advanced Networks and/or FQHCs participating in CCIP with the involvement of the CCIP participants and other key healthcare stakeholders to be transitioned to local oversight. Efforts are already underway to coordinate these activities with DPH and other public health efforts.

Intervention Highlights

- The **Community Health Collaboratives** will be the primary vehicle of community consensus.
- To establish the Community Health Collaboartives the technical assistance vendor will convene healthcare stakeholders from **across the healthcare continuum** and **relevant community stakeholders**
- The stakeholders convened will be representative of the community being served and has to include **consumer representation**
- The community collaborative will be responsible for establishing protocols and processes for **network linkages to shared resources in the community** and can serve as a resource for determining additional community needs (e.g.; transitions from hospitals to home)
- **Prioritization of the linkages** established will be informed by an **assessment of the communities needs and resources conducted by the community collaborative**