Practice Transformation Taskforce Meeting

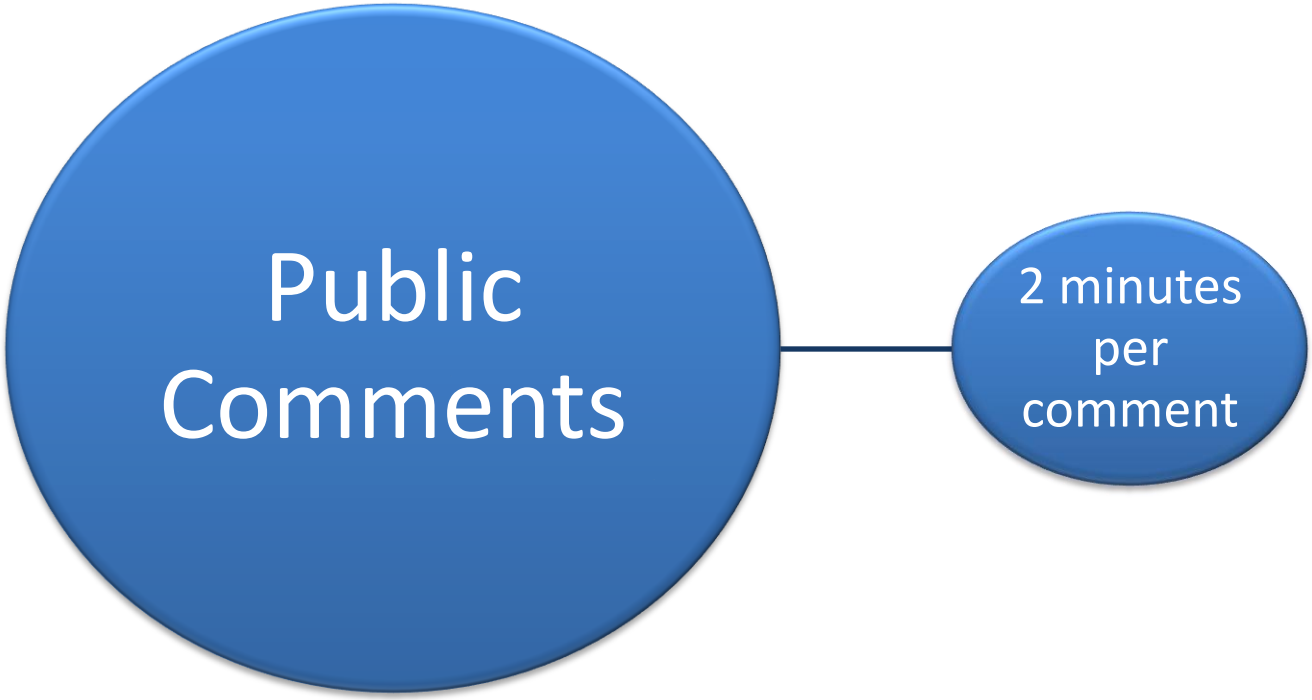
November 3, 2015

Meeting Agenda

Agenda Item	Allotted Time
1. Introduction	**5 minutes**
2. Public Comment	**10 minutes**
3. Minutes of September 1st Meeting	**3 minutes**
4. Purpose of Today's Meeting	**2 minutes**

5. Review of Public Comments
• Complex patients
  • Definition
  • Intervention
• PTTF member consensus around report
• Telehealth focus
• Burdens on small providers
• Comprehensive Medication Management standards
• Coordination with DSS/MQISSP initiatives
	80 minutes

6. Review of CCIP Timeline & Next Steps • HISC presentation • Public comment • Role moving forward	**20 minutes**


Public Comments
2 minutes per comment

Purpose of Today's Meeting

- Review select comments submitted to the PMO on the second draft of the CCIP report
- Vet the PMO disposition on the comments and proposed next steps
- Discuss timeline for finishing the CCIP report and standards

“Complex Patient” Definition

Definition the patient for the complex care intervention

Comment Summary

Two Commenters requested that the PTTF revisit the definition of “complex patients” for the complex care intervention. There is a distinction between patients with complex health needs and complex patients, and there may be overlap with the Medicaid population, so commenters believe the PTTF needs to provide additional clarity.

Discussion Notes

- There are many factors that influence complexity and their difficulty managing health conditions including: number of chronic conditions, severity of chronic conditions, and social determinants.
- There is a balance between being prescriptive to ensure minimum standards and allowing the necessary flexibility for networks to cater to local needs.
- Does the current definition achieve that balance for Connecticut?

"Complex Patient" Definition

PTTF's current definition as revised at the last PTTF meeting is as follows:

- 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.

Commenters' Concern

Patients with an acute condition or a single uncomplicated chronic condition (such as asthma or diabetes) and multiple detrimental social determinants of health may be at high-risk for hospitalization, multiple ER visits, or hospital re-admissions due an uncontrolled medical condition in the short-term. But they are not truly complex patients and offering comprehensive care management services to these patients does not result in long term cost savings.

“Complex Patient” Definition

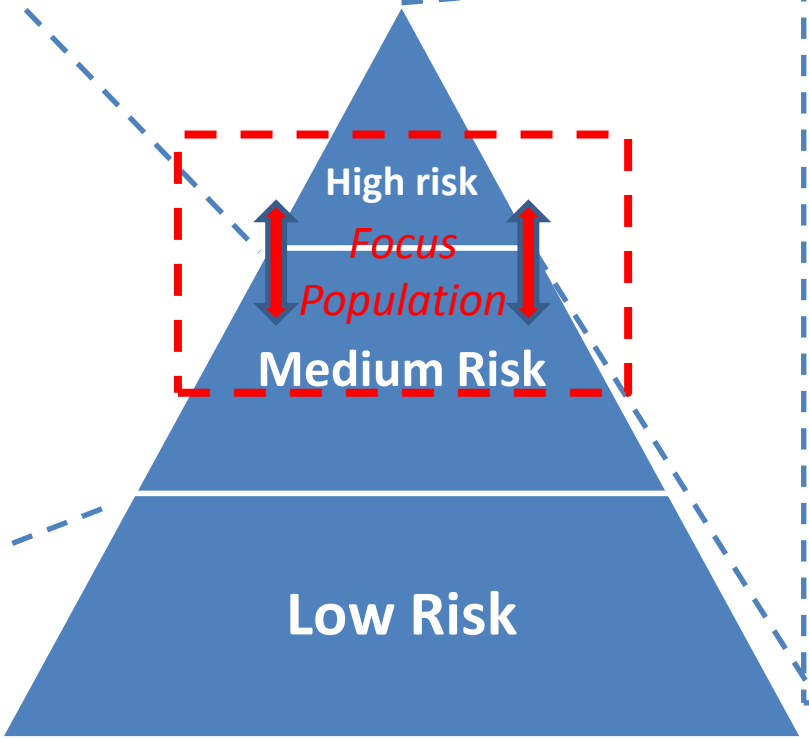
There are several sub-categories of “complex” who are experiencing poor management of health conditions

Medicaid | **Medicare** | **Commercial**

Conditions & Priorities

- Limited chronic conditions in a more stable state
- Potential prevalence of socio-economic and psycho-social barriers
- Occasional bursts of utilization due to poor management
- Incorporate team-based coordinated care
- Address foreseeable clinical and socio-economic complications

Population Health Pyramid



Conditions & Priorities

- Multiple chronic conditions with high acuity
- Psycho-social and socio-economic barriers
- Frequent hospitalizations and ER visits
- High-costs and poor outcomes
- Intensive care management
- Community resources navigation
- Address non-clinical needs
- Effective care coordination and care transition planning

Complex Patient Intervention Standards

Revising the intervention standards for patients with complex health needs

Comment Summary

Commenter requested some modifications to the design of the complex care standards, most notably to conduct a needs assessment before forming the care team

Discussion Notes

- Are these changes compatible with the original intent of the current standards?
- Can these changes be vetted during public comment period?
- Does this fit with the demonstrated need in Connecticut?
- Is it clear the role that the various stakeholders play in executing this intervention?

Complex Patient Intervention Standards

The current high-level design is:

1. Identify individuals with complex needs
2. Establish a comprehensive care team
3. Connect individuals to the comprehensive care team
4. Conduct person-centered assessment
5. Develop a comprehensive care plan
6. Execute and monitor the comprehensive care plan
7. Identify when individual is ready to transition to self-directed care maintenance
8. Monitor individuals to reconnect to comprehensive care team when needed
9. Evaluate the effectiveness of the intervention

Complex Patient Intervention Standards

The changes to the high-level design would be along the lines of:

1. Identify the focus population with the help of referrals or data analysis;
2. Dedicated trained care manager/management team conducts a comprehensive assessment of the individual's need for health supports and social services;
3. Develop an individualized health care plan for the patient with input from the primary care team, patient, patient's family and caregiver and creates a program for updating the care plan;
4. Form a comprehensive care team to address patient's individualized needs
5. Communicate care plan to PCP, patient, family, care givers, providers, and community support services; and engage patient and patient's family/caregivers in self-management goals;
6. Execute the care plan ensuring updates are communicated to the care team (including the patient, family, and caregivers), connecting the individual to needed clinical and non-clinical services, and engaging patient, family, and caregivers in plan to meet self-directed care management goals;
7. Reassess patient on an on-going basis (rec'd every 6-12 months);
8. Track the individual, periodically reassess, and evaluate self-management skills;
9. Reassess patient's care plan goals and conduct a care team meeting (including PCP, patient, family and caregivers) when transitioning patients between levels of care
10. Develop training modules for care team, community supports, and patient.

PTTF Support for Report and Recommendations

Consensus around report content

Comment Summary

Commenters had conflicting points:

- report accurately reflected the PTTF's intent
- report did not accurately convey the PTTF's discussion

Discussion Notes

- The PMO intends to continue to engage the PTTF for continued support to refine certain aspects of the CCIP program over time and through the transformation vendor.
- But the PMO would like to confirm PTTF endorsement of the report and recommendations.
- Does the report convey the nature of the discussions of the PTTF?
- Does the PTTF feel that there major issues that need to be addressed?

E-Consults vs Telehealth

Comment Summary

Commenter believes that the electronic consults standards are too limiting and that the standards should be around a broader telehealth initiative with multiple sub-specialties (e.g. tele-dermatology, tele-dentistry) including e-consults as a component. Another commenter authored a broader introduction to telehealth and the evidence base demonstrating improved outcomes and lower costs.

Discussion Notes

- CCIP is designed to build practice capabilities in Connecticut over time. The PMO acknowledges the growth in telehealth services and the increased evidence base to support telehealth services in certain instances.
- The PMO is concerned about the lack of review time of the evidence base for other telehealth services.
- Can the PTTF incorporate a broader intro paragraph on the possibility of expanding telehealth beyond e-consults and work to incorporate additional telehealth services into CCIP over time?

Burden on Small Providers

Comment Summary

Commenter is concerned that it will be very difficult for networks composed of independent practices to meet the standards outlined in this document. The responsibility for effecting most of the objectives as currently written in the CCIP lies with the network. This is easier to achieve when the AMHs are all employed by the network, e.g. NEMG, than when they are independent practices.

Discussion Notes

- The PMO would like to gauge whether this concern is felt across PTTF members and whether there are possible remedies.
- Possible options include:
  - Retaining standards and core requirements as they are
  - Providing financial support for transformation
  - Relaxing the standards for networks comprised of independent practices
  - Other?

Comprehensive Medication Management Standards

Comment Summary

Commenter makes several language edits to the CMM elective standards to emphasize credentialing, education and training, and processes that are in line with the JCPP Pharmacists' Patient Care Processes.

Discussion Notes

- The changes appear to be in line with the discussion at the last PTTF meeting.
- Are the changes to the standards feasible for networks to implement?
- Can other members of the care team fulfill some of the patient education initiatives coordinating with the pharmacists?

Coordination with DSS/MQISSP Initiatives

DSS and the PMO have released comments pertaining to MQISSP and CCIP and have opened a dialogue regarding coordination of these programs

Highlights

- The SIM PMO and DSS have in consultation with the Care Management Committee of MAPOC developed a protocol document to guide communications between the joint work of MAPOC and SIM, which will be expanded to include coordination with the PTTF
  - https://www.cga.ct.gov/med/comm1.asp?sYear=2015

- In the SIM model test grant, the combination of MQISSP and CCIP reforms are being tested. DSS is responsible for MQISSP and the criteria for selecting providers. Information on the MQISSP model design elements can be found here:
  - https://www.cga.ct.gov/med/default.asp

- CCIP is focused on establishing minimum standards of capabilities among ANs/FQHCs and is not intended to supplant activities that are already in place.

- The PMO and DSS are preparing a one year extension of the originally planned implementation date, which will permit more time for discussion of how MQISSP and CCIP interrelate.

Review of CCIP Timeline

Next Steps & PTTF Role

- Release 3rd draft of report to PTTF and HISC on 11/5
- Present report and CCIP to HISC on 11/12
  - Public comment begins
- Incorporate CCIP standards into MQISSP RFP in 2016
  - Additional PTTF meeting before to review public comment and make additional edits
- Ongoing follow-up and implementation oversight
  - TA vendor RFP
  - Continued planning with respect to Community Health Collaboratives
  - Oversight of CCIP implementation including successes and burdens

Questions & Discussion