Community & Clinical Integration Program and Requirement Elements of the Medicaid Quality Improvement and Shared Savings Program

Proposed Alignment Strategy

Clinical and Community Integration Program (CCIP)

SIM promotes care delivery reform at the level of the individual practice and at the level of the Advanced Network (AN) or FQHC with which individual practices are affiliated. CCIP is intended to promote the advancement of ANs and FQHCs over the three year grant period (2016-2019) by promoting the achievement of new capabilities through a combination of technical assistance and, potentially, transformation awards.[1] The capabilities are set forth in a set of core and elective standards, build on the standards that exist today for medical homes. The CCIP standards focus on improving healthcare outcomes for all patients regardless of their insurance carrier (i.e., payer).

Participants

The CCIP program standards are intended to apply to those entities that DSS selects to participate in MQISSP, but not to those organizations that are participating in the CMMI funded Practice Transformation Network (PTN) initiatives. The PMO is working with PTN participants (CHCACT and UConn Health) to determine whether there may be some areas of the CCIP that are not a focus of PTN, and for which CCIP might provide support to PTN participants. Of particular interest to CHCACT PTN participants are those standards that relate to Community Health Workers and e-consultation.

Customized Technical Assistance

The goal of the CCIP program is to ensure that participating organizations have the capabilities necessary to effectively support individuals with complex health care needs, to identify and reduce health equity gaps, and to better identify and support individuals with behavioral health needs. The program focuses on better engaging patients as partners in their own healthcare and helping to build coordinated systems that support patients' clinical and non-clinical needs. The CCIP capabilities are reflected in the CCIP core standards.

The SIM PMO intends to procure one or more vendors to provide the technical assistance to ANs and FQHCs to help them meet these core standards. The PMO intends to customize the technical assistance process so that ANs and FQHCs receive support that is tailored to their needs. The vendor(s) will be responsible for conducting an assessment with the ANs and FQHCs to identify those areas where they do not meet the standards. The vendor(s) will work with the ANs and FQHCs to develop a technical assistance plan that focuses on areas where there are gaps or opportunities for improvement.

It is important to note that CCIP is not intended to introduce new or separate programs different from those that ANs and FQHCs may already have in place. Instead the effort is primarily intended to introduce new capabilities within existing programs or augment capabilities that may already exist, such

[1] The PMO anticipates requesting CMMI approval to allocate a portion of the $45 million grant for the purpose of making transformation awards to CCIP participating ANs and FQHCs that are not participating in PTN.

as those associated with recognition as a PCMH. For example, we anticipate that many participants will already have care teams in place, but may not have effective processes for including community health workers as members of the team or linking with community supports to address an individual's non-clinical needs.

CCIP and the MQISSP Required Elements

The MQISSP program introduces an array of requirements that participating providers must meet as a condition of participation. The MQISSP required elements focus on care coordination, integration of behavioral health, the care of special populations, and cultural and linguistic appropriateness standards. DSS and the PMO are interested in taking advantage of opportunities to align the MQISSP required elements and the CCIP program standards. To support this process, the PMO prepared the table below, which identifies those CCIP standards that pertain most directly to the corresponding MQISSP required elements. This is done for all elements, even those for FQHC only, recognizing that CCIP will not apply to nearly all FQHCs.

Yellow highlighting on the left is used to identify MQISSP elements that could incorporated into the CCIP standards. Yellow highlighting on the right shows how the CCIP standards might be modified or expanded to reflect MQISSP elements. Comments note areas that might benefit from further discussion.

MQISSP Care Coordination Requirements and CCIP Standards

#	MQISSP Care Coordination Requirement	Notes about CCIP's alignment with MQISSP requirement
1	Employ a care coordinator with behavioral health education, training, and/or experience.	This MQISSP requirement aligns with the comprehensive care management standards, which require "basic" behavioral health training for all care team members: **CCM.4.b** The comprehensive care team fulfills several functions including clinical care management and coordination, community focused care coordination to link individuals to needed social services and supports, and culturally and linguistically appropriate self-care management education. **CCM.4.c.i** The network ensures that each care team: designates a lead care manager with responsibility for facilitating an effective comprehensive care team process and ensuring the achievement of the individual's lifestyle and clinical outcome goals. **CCM.4.f** Basic behavioral health training appropriate for all comprehensive community care team members is provided. **Comment:** Consider defining for both MQISSP and CCIP the nature of the BH training that would be required.

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2	FQHC only: Employ a care coordinator with behavioral health experience who serves as a member of the interdisciplinary team and has the responsibility for • tracking patients, • reporting adverse symptoms to the clinical team, • providing patient education, • supporting treatment adherence, • taking action when non-adherence occurs or symptoms worsen, • and providing psychosocial support and referrals to behavioral health services outside of the clinic when indicated.	See above. Also: CCIP standards include non-highlighted portions: **CCM.4.b** The comprehensive care team fulfills several functions including clinical care management and coordination, community focused care coordination to link individuals to needed social services and supports, and culturally and linguistically appropriate self-care management education. **CCM. 6.b.** The network establishes protocols for monitoring individual progress on the individualized care plan, reporting adverse symptoms to the care team, supporting treatment adherence, and taking action when non-adherence occurs or symptoms worsen. **BH.2.e.ii** Designating an individual to be responsible for tracking and confirming referrals **Question:** Harmonize care team terminology? Interdisciplinary care team versus comprehensive care team.
3	Use standardized tools to expand behavioral health screenings beyond depression.	CCIP behavioral health standards are consistent with this MQISSP requirement but more specific as to conditions and instruments: **BH.1.a** The network uses a screening tool for behavioral health needs that is comprehensive and designed to identify a broad range of behavioral health needs at a minimum including: i) Depression ii) Anxiety iii) Substance abuse iv) Trauma **BH.1.b** The network develops a screening tool…that includes: i) The PHQ-9 to screen for depression ii) Standardized and validated screening tools for behavioral health needs outside of depression
4	Promote universal screening for behavioral health conditions across all populations, not just those traditionally identified.	CCIP behavioral health standards appear to be consistent with this MQISSP requirement: **BH.1.a** The network uses a screening tool for behavioral health needs that is comprehensive and designed to identify a broad range of behavioral health needs **BH.1.e** The network conducts the behavioral health screening no less often than every two years

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5	Maintain a copy of the psychiatric advance directive in the patient's file.	Not a CCIP standard but does not conflict with any CCIP standard.
6	**FQHC only:** Develop Wellness Recovery Action Plan in collaboration with patient and family. Maintain a copy of the Wellness Recovery Action Plan in the patient's file	CCIP Behavioral Health standard also requires a behavioral healthcare plan as follows: **BH.3.i** The behavioral healthcare plan outlines treatment goals, including when follow up is required and who is responsible for follow up **BH.4.a** The network utilizes individual tracking tool to assess and document individual progress at one year and other intervals as determined by the provider
7	**FQHC only:** Expand the development and implementation of the care plan for transition aged youth (ages 12-17) with behavioral health challenges.	Not a CCIP standard but does not conflict with any CCIP standard. The above "behavioral healthcare plan" does not have any age exclusions. However, CCIP focus is on unidentified problems and less so on care of individuals with chronic behavioral health problems, which is the focus of this MQISSP requirement.
8	**FQHC only:** Require use of an interdisciplinary team that includes behavioral health specialists. The team has the responsibility for • driving integrated physical and behavioral health, • conduct interdisciplinary team case review meetings at least monthly, • promote shared appointments, • and develop a comprehensive care plan outlining coordination of physical health and behavioral health care needs.	CCIP comprehensive care management standards provide for a BH specialist when the person centered assessment identifies BH needs. **CCM.3.a.** The comprehensive care team including the individual and their natural supports collaborate to develop the individualized care plan that reflects the person-centered needs assessment and includes the following features: i) Reflects the individual's values, preferences, clinical outcome goals, and lifestyle goals ii) Establishes clinical care goals related to physical and behavioral health needs iii) Establishes social health goals to address social determinant risks iv) Identifies referrals necessary to address clinical and social health goals and a plan for linkage and coordination **CCM.4.c.iii** Comprehensive care team has timely access to or has a comprehensive care team member who is a licensed behavioral health specialist capable of a conducting a comprehensive behavioral health assessment **CCM.6.a** The network establishes protocols for regular comprehensive care team meetings that establish: v) Who is required to attend

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		vi) The frequency of the meetings vii) The format of the meetings (i.e.; via conference call, in person, etc.) A standardized reporting form on the individual's progress and risks **Comment:** CCIP comprehensive care team standard is flexible as to whether BH care is coordinated rather than coordinated. **Comment:** "Promote shared appointments" could be added as a care team task once the definition is clarified.
9	Require annual cultural competency training for all practice staff. Cultural competency training will include the needs of individuals with disabilities.	CCIP standards align with this MQISSP requirement. **CCM.4.f.v** The network establishes training protocols related to delivering culturally and linguistically appropriate services consistent with Department of Health and Human Services, Office of Minority Health, CLAS standards, including the needs of individuals with disabilities **CCM.4.g** The network ensures that training is provided: i) To all practice staff that are part of or engage with the comprehensive care team ii) On an annual basis to incorporate new concepts and guidelines and reinforce initial training
10	Expand the individual care plan to assess the impact culture has on health outcomes.	CCIP standards align with and expand upon this MQISSP requirement. **CCM.2.a** To understand the historical and current clinical, social and behavioral needs of the individual, which will inform the individualized care plan, the network conducts a person-centered needs assessment with individuals identified in standard 1. The assessment includes: i) Preferred language ii) Family/social/cultural characteristics iii) Assessment of health literacy iv) Social determinant risks v) Personal preferences, values, needs, and strengths **CCM.3.a** The comprehensive care team including the individual and their natural supports collaborate to develop the individualized care plan that reflects the person-centered needs assessment and includes the following features: i) Reflects the individual's values, preferences, clinical

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		outcome goals, and lifestyle goals iii) Establishes social health goals to address social determinant risks **Question:** What is the difference between this MQISSP "individual care plan" and previously mentioned MQISSP "comprehensive care plan"? (see response to #8) **Question:** Harmonize MQISSP and CCIP terminology? Comprehensive care plan vs individualized care plan
11	Expand the CAHPS survey to include the supplemental cultural competency item set.	Does not conflict with CCIP standards, which do not require that providers conduct care experience surveys.
12	Require compliance with Culturally & Linguistically Appropriate Service Standards (CLAS) as defined by the Department of Health and Human Services, Office of Minority Health:	See below.
13	1) Provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs	This requirement aligns with CCM and HEI. **CCM.4.f.v** The network establishes training protocols related to: Delivering culturally and linguistically appropriate services consistent with Department of Health and Human Services, Office of Minority Health, CLAS standards **CCM.4.g** The network ensures that training is provided: i) To all practice staff that are part of or engage with the comprehensive care team ii) On an annual basis to incorporate new concepts and guidelines and reinforce initial training **HEI-P2.1** Create a more culturally and linguistically sensitive environment a) The identified practices provide culturally and linguistically appropriate services informed by the root-cause analysis conducted around the identified healthcare disparity. i) Practices provide interpretation/bilingual services as necessary ii) Practices provide printed materials (education and other materials) that meet the language and literacy needs of the individual

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14	2) Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices and allocated resources.	Not currently a CCIP standard.
15	3) Recruit, promote and support a culturally and linguistically diverse governance, leadership and workforce that are responsive to the population in the service area.	Not currently a CCIP standard. Propose modified HE.P1 standard as follows: **HEI-P1.1.** d. Network conducts a workforce analysis that includes analyzing the panel population in the service area, evaluating the ability of the workforce to meet the population's linguistic and cultural needs, and implementing a plan to address workforce gap.
16	4) Educate and train governance, leadership and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.	Not currently a CCIP standard.
17	5) Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.	This requirement aligns with HEI. **HEI-P2.1** Create a more culturally and linguistically sensitive environment a) The identified practices provide culturally and linguistically appropriate services informed by the root-cause analysis conducted around the identified healthcare disparity. i) Practices provide interpretation/bilingual services as necessary ii) Practices provide printed materials (education and other materials) that meet the language and literacy needs of the individual
18	6) Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.	Not currently a CCIP standard.
19	7) Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.	Not currently a CCIP standard.

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20	8) Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.	This requirement aligns with HEI. **HEI-P2.1** Create a more culturally and linguistically sensitive environment a) The identified practices provide culturally and linguistically appropriate services informed by the root-cause analysis conducted around the identified healthcare disparity. ii) Practices provide printed materials (education and other materials) that meet the language and literacy needs of the individual
21	9) Establish culturally and linguistically appropriate goals, policies and management accountability, and infuse them throughout the organizations' planning and operations.	Not currently a CCIP standard.
22	10) Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into assessment measurement and continuous quality improvement activities.	This requirement aligns with HEI. **HEI-P1.1 Expand the collection, reporting, and analysis of standardized data stratified by sub-populations** a) The network identifies valid clinical and care experience performance measures to compare clinical performance between sub-populations **HEI-P1.1.b** The network analyzes the identified clinical performance and care experience measures stratified by race/ethnicity, language, and other demographic markers such as sexual orientation and gender identity i) This will require that the network at a minimum capture Office of Management and Budget (OMB) race/ethnicity categories and preferred language in their EMR **HEI-P1.4.1.a** The network demonstrates that the intervention is reducing the healthcare disparity identified by: i) Tracking aggregate clinical outcome and care experience measures aligned with the measures used to establish that a disparity existed ii) Achieving improved performance on measures for which a disparity was identified **HEI-P1.4.1.b** Identify opportunities for quality and process

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		improvement. This will require: i) Defining process and outcome measures for the interventions pursued
23	11) Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.	This requirement aligns with HEI. **HEI-P1.1** Expand the collection, reporting, and analysis of standardized data stratified by sub-population
24	12) Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.	Not currently a CCIP standard.
25	13) Partner with the community to design, implement and evaluate policies, practices and services to ensure cultural and linguistic appropriateness.	This requirement aligns with HEI. **HEI-P1.3 Implement at least one intervention to address the identified disparity** b) The network conducts a root cause analysis for the disparity identified for intervention and develops an intervention informed by this analysis c) The root cause analysis utilizes: i) Relevant clinical data ii) Input from the focus sub-population for whom a disparity was identified iii) Input from the focus sub-population solicited through various venues **HEI-P1.4.1.a** The network demonstrates that the intervention is reducing the healthcare disparity identified by: i) Tracking aggregate clinical outcome and care experience measures aligned with the measures used to establish that a disparity existed ii) Achieving improved performance on measures for which a disparity was identified iii) Sharing evaluation findings with the focus sub-population
26	14) Create conflict- and grievance-resolution processes that are culturally and linguistically	Not currently a CCIP standard.

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	appropriate to identify, prevent and resolve conflicts or complaints.	
27	15) Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents and the general public	Not currently a CCIP standard.
28	**Providers select <u>at least one</u> option:** • Employ a full-time care coordinator dedicated solely to care coordination activities • Assign care coordination activities to multiple staff within a practice • Contract with an external agency to work with the practice to provide care coordination.	Aligns with the CCIP comprehensive care management (CCM) standards. See response to #1 **CCM.4.c.i** The network ensures that each care team: designates a lead care manager with responsibility for facilitating an effective comprehensive care team process and ensuring the achievement of the individual's lifestyle and clinical outcome goals. **Question:** Harmonize care coordinator terminology? Care coordinator versus care manager?
29	Define minimum care coordinator education and experience requirements within the MQISSP and determine if leveraging non-licensed staff, such as CHWs, is desired	CCIP builds on this capability by requiring the capability to integrate CHWs in CCM and HEI interventions. **CCM.4.c.ii** The network ensures that each care team: ii) has the capability to add a community health worker to fulfill community-focused coordination functions **HEI-P2.2 The network establishes a CHW capability** The network determines the best strategy for incorporating community health workers and community health worker field supervisor(s) into the primary care practices.
30	Advance care planning discussion for children and youth with special health care needs	Not currently a CCIP standard.
31	Include school related information in the health assessment and health record such as: An individualized education program or 504 plan; assessing patient need for advocacy from the provider; determine how the child is doing in school; document school name and primary contact.	Not currently a CCIP standard.

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32	Expand the health assessment to include questions about durable medical equipment, vendor preferences, home health medical supplies, home health vendor preferences, home and vehicle modifications, prevention of wounds for individuals at risk for wounds, and special physical and communication accommodations needed during medical visit.	Not currently a CCIP standard.
33	Adjust appointment times for individuals who require additional time to address physical accommodations, communication needs, and other unique needs.	Not currently a CCIP standard.
34	Develop and require mandatory disability competency trainings to address the care of individuals with physical and intellectual disabilities.	See response to #9 for training to include individuals with disabilities.
35	Acquire accessible equipment to address physical barriers to care (wheelchair scales, high/low exam tables, lifts)	Not currently a CCIP standard.
36	Address communication barriers to care (e.g. offer information in Braille). Providers may coordinate with the Medical ASO to obtain available materials.	This requirement aligns with HEI. **HEI-P2.1** Create a more culturally and linguistically sensitive environment a) The identified practices provide culturally and linguistically appropriate services informed by the root-cause analysis conducted around the identified healthcare disparity. i) Practices provide interpretation/bilingual services as necessary ii) Practices provide printed materials (education and other materials) that meet the language and literacy needs of the individual
37	Expand the resource list of community providers to include providers who specialize in or demonstrate competencies in the care of individuals with disabilities	Not currently a CCIP standard.

Note:

CCM = Comprehensive Care Management Standards

HEI-P1 = Health Equity Improvement Standard – Part 1 (quality improvement)

HEI-P2 = Health Equity Improvement Standard – Part 2 (pilot)

BH = Integrated Behavioral Health Standard