DRAFT

Practice Transformation Task Force

PTTF Meeting

March 22, 2016

State Innovation Model

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

Meeting Agenda

Item	Allotted Time
1. Introductions	5
2. Public Comments	10
3. Minutes	5
4.Purpose of Today's Meeting	5
5. CCIP Comments & Proposed Edits	80
6. CCIP Timeline	10
9. Next Steps	5

Purpose of Today's Meeting

- Discuss public comments to CCIP Draft 4
- Discuss proposed implementation strategy and edits for final standards and report

CCIP Draft 4 Public Comments Summary

General Comments in Support of the Report and Process:

- CCIP builds on proven innovations and is based on extensive research
- The process for developing the report and standards has been inclusive, an ongoing iterative process with multiple periods of public comment, meetings, and webinars
- Providers requested consistency with standards and requirements from the beginning of the SIM process, which led to the development of standards that will benefit all patients
- The CCIP Program will provide the necessary TA and potential transformation awards to aid with the standards, helping to reduce provider burden

CCIP Draft 4 Public Comments Summary

- Training, support, and development of feedback mechanisms is crucial for providers, leaders, and cross-organizational teams. New roles must be well defined, as well as workflows and measures for team-based care.
- Care plans are a great approach for patients with complex needs, as long as they are available when needed and editable by the Care Team.
- Equity in utilization does not equate to improved health outcomes. CCIP addresses this by including specific standards and accountability to address health equity.

CCIP Implementation Strategy

Concern: Not enough time for input on implementation strategy

- DSS and the PMO have prepared a plan for coordinating the launch of MQISSP and CCIP
- DSS has agreed to embed requirements related to CCIP standards within the Request for Proposals (RFP) through which DSS will procure Participating Entities for the Medicaid Quality Improvement and Shared Savings Program (MQISSP)
- DSS' reason for doing so is that it acknowledges the value of promoting activities that will promote and support the needs of Medicaid beneficiaries who are already being served by advanced networks

CCIP Implementation: Two Tracks

- The DSS MQISSP RFP will offer **two tracks**, from which applicant entities must choose
- The **first track** will require Participating Entities to participate in CCIP technical assistance, but will not require demonstrated achievement of the CCIP standards as a condition for continued participation in MQISSP
- The **second track** will enable Participating Entities to indicate that they agree to be bound by CCIP standards. Only these entities will be eligible for potential transformation awards
- Over the course of the first MQISSP performance period, DSS and the SIM PMO will carefully review the experience of Participating Entities that agree to be bound by the CCIP standards, will seek additional comment on the CCIP standards, and may adjust the CCIP standards, as needed.
- For the second wave MQISSP procurement, achievement of the CCIP standards, as revised, will be a condition for all MQISSP Participating Entities, including those entities that were exempt during the first wave

CCIP Implementation: Request for Accommodation

Suggestion: Better harmonize with existing Medicaid Intensive Care Management Program and PCMH coordination efforts

Proposed accommodations:

- Exemption: Allow provider to request an exemption from or adjustment to a CCIP requirement that conflicts with, or would otherwise disrupt, their activities in relations to a PCMH standard or their ability to coordinate with the CHNCT Intensive Care Management program.

- Coordination Protocols: Advanced Networks and FQHCs participating in CCIP will be required to develop coordination protocols with CHNCT and Beacon Health Options that set mutually agreeable processes for handling coordination. The protocols may specify, for example, how individual choice should factor into decisions about who leads the care management process and for which individuals one or another program might be better suited.

CCIP Implementation: Request for Accommodation

Other accommodations:

- Timetable: Additional 6-months
- Alignment: If the standards do not fully align with needs of the Advanced Network and its patient populations, the PMO may work with the provider and vendor(s) to consider how the core standards might be adapted to better meet their population's needs
- Hardship: Accommodation regarding particular element if the costs associated with meeting this element presents an insurmountable barrier

CORE STANDARD 1: COMPREHENSIVE CARE MANAGEMENT

COMMENTS

CCIP Draft

Current Language CCM Standard #1:

1. The network identifies individuals with complex health needs who will benefit from the support of a comprehensive care team using an analytics-based risk stratification methodology that takes into consideration utilization data (claims-based); clinical, behavioral, and social determinant data (EMR-based); and provider referral.

CCIP Draft 4 Public Comments Summary

- "Adequate housing is a significant determinant of health and health costs…The subset of those individuals experiencing literal homelessness…is likely to have significantly greater need and higher cost."
- "Many of Medicaid's highest cost beneficiaries are individuals with complex and co-occurring health and behavioral health challenges experience homelessness and housing crisis."
- Would require a data matching between administrative data and a data stream that includes information on housing instability (e.g., Homeless Management Information System, state agency data).

Suggestion: Include data on homelessness/housing stability when identifying high need, high cost users

CCIP Draft 4 Public Comments Summary

Suggestion: Provider organizations would benefit from technical assistance in identifying both the currently complex patient and those with rising risk of complexity

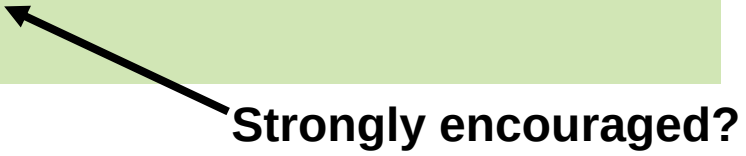
Suggestion: When identifying individuals with complex health needs, require a referral process to be an automated system to reach as many people as possible

CCIP Draft: Proposed Edit

Proposed edit to CCM Standard:

1. The network identifies individuals with complex health needs who will benefit from the support of a comprehensive care team using an analytics-based risk stratification methodology **that identifies current and rising risk and** ~~that~~ takes into consideration utilization data (claims-based); clinical, behavioral, and social determinant data (EMR-based); and provider referral. **Integration with and use of external data sources (e.g., Homeless Management Information System, state agency data) is also recommended.***

2. **Network has a process to automate referral to care team for meeting identified risk threshold.**



*Potential area for SIM funded HIT solution?

CCIP Draft 4 Public Comments Summary

Suggestion: Integrate a resource directory to promote referrals to community supports

Proposed edit to CCM Standard 5: Execute & monitor individualized care plan

e. The network establishes a process and protocols for **accessing an up-to-date resource directory** connecting individuals to needed community ~~**services**~~ **resources** (i.e.; social support services), **verifying linkages,** ~~**and**~~ tracking barriers to care, and providing facilitation to address such barriers (i.e., rides to appointments).

CCIP Draft 4 Public Comments Summary

Other suggestions related to integrating health and housing supports

- Expand and sustain the Patient Navigator workforce in supportive housing piloted by the CT Integrated Health & Housing Neighborhoods (CIHHN) – where Patient Navigators provide hands-on assistance to CIHHN tenants
- Build collaborations between health, behavioral health and housing systems (e.g., between an FQHC and a housing authority)
- Expand and sustain existing supportive housing initiatives targeting high utilizers
- Consider testing a medical respite model directly linked to permanent supportive housing in one or more communities
- Use the Community Care Team (CCT) model, usually based out of hospitals

CCIP Draft 4 Public Comments Summary

Suggestion: Encourage the inclusion of providers on the outpatient care team with palliative care skills focused on living with chronic disease, rather than end-of-life care

- "Perhaps implicit in the comprehensive care management standards is redefining palliative care interventions, away from end of life planning and into the outpatient setting with a focus on LIVING with chronic illness. If including professionals with palliative care skills on the OP care team is not one of the elective standards, explicitly mentioning the desirability of their inclusion in the comprehensive care management team would be helpful in promoting this much needed intervention. The literature is pretty clear about the benefits to patient centered care, quality outcomes and cost-of-care"

CCIP Draft 4 Public Comments Summary

Proposed edit to CCM Standard 4.d

- The network ensures that each care team:
  - designates a lead care coordinator with responsibility for facilitating an effective comprehensive care team process and ensuring the achievement of the individual's lifestyle and clinical outcome goals.
  - has the capability to add a community health worker to fulfill community-focused coordination functions
  - 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
  - adds comprehensive care team members outside of the above core functions (i.e.; dieticians, pharmacists, **palliative care practitioners,** etc.) on an as needed basis depending on the needs identified in the person-centered assessment

CORE STANDARD 2: HEALTH EQUITY COMMENTS

Race/Ethnicity Categories

Concern: How do we ensure health systems are analyzing data and deploying interventions for populations that make up a small percentage of their panels, or are hidden within the broader OMB categories, but are experiencing substantial health disparities

- "A critical issue in race and ethnicity data collection is how many categories of race and ethnicity to include. Having every possible racial and ethnic category available in a data collection tool may be quite cumbersome and require sophisticated information technology. On the other hand, collecting data using very broad categories may not be useful for organizations serving very diverse populations. For example, the Asian category includes individuals from India, China, Korea and other countries with significantly different cultures and beliefs." – RWJF

SIM Southeast Asian Listening Session revealed that members of the Southeast Asian community in Connecticut face specific healthcare challenges, including high rates of diabetes and hypertension

Current language

Core Standard 2: Health Equity Improvement

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. Such measures:

Ii. Include, at a minimum, Office of Management and Budget (OMB) race/ethnicity categories and preferred language in their EMR

Race

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White

Ethnicity

- Hispanic or Latino
- Not Hispanic or Latino

“Granular Ethnicities”

- The OMB categories are not sufficiently descriptive to distinguish among locally relevant ethnic populations that face unique health problems and may have dissimilar patterns of care and outcomes (Hasnain-Wynia and Baker, 2006) (Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement, Institute of Medicine (2009))

- OMB encourages **additional granularity** where it is supported by sample size and as long as the additional detail can be aggregated back to the minimum standard set of race and ethnicity categories (https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status)

New ONC Requirement for Certified EHRs

45 CFR Part 170
2015 Edition Health Information Technology (Health IT) Certification Criteria, 2015 Edition Base Electronic Health Record (EHR) Definition, and ONC Health IT Certification Program Modifications; Final Rule

Race/ethnicity

- Requirement that allows provider to "record each one of a patient's races and ethnicities in accordance with, at a minimum, the ''Race & Ethnicity—CDC'' code system in the PHIN Vocabulary Access and Distribution System (VADS), Release 3.3.9 18 and aggregate each one of a patient's races and ethnicities to the categories in the OMB standard for race and ethnicity" (CDC list has 900+ categories)

Language

- In the Proposed Rule, we proposed to require the use of the Internet Engineering Task Force (IETF) Request for Comments (RFC) 5646 19 standard for preferred language

Current language

Core Standard 2: Health Equity Improvement, Part 1

1. Expand the collection, reporting, and analysis of standardized data stratified by sub-populations

   a. Require that the network implement a plan to collect additional race and ethnicity categories for its patient population. The selection of additional granular categories must:

      i. Draw from the recognized "Race & Ethnicity—CDC" code system in the PHIN Vocabulary Access and Distribution System (VADS)) or a comparable alternative;

      ii. Have the capacity to be aggregated to the broader OMB categories;

      iii. Be representative of the population it serves, validated by (a) data (e.g., census tract data, surveys of the population) and; (b) input from community and consumer members if the network is implementing fewer than the 900+ available categories

Current language

Core Standard 2: Health Equity Improvement, Part 1

1. Expand the collection, reporting, and analysis of standardized data stratified by sub-populations

   b. Require that the network implement a plan to collect additional language categories for its patient population. The selection of language categories must:

   i. Draw from the Internet Engineering Task Force (IETF) Request for Comments (RFC) 5646 19 standard for preferred language, and

   ii. Be representative of the population it serves, validated by (a) data (e.g., census tract data, surveys of the population) and; (b) input from community and consumer members

Current language

Core Standard 2: Health Equity Improvement, Part 1

1. Expand the collection, reporting, and analysis of standardized data stratified by sub-populations

   c. The network identifies valid clinical and care experience performance measures to compare clinical performance between sub-populations. Such measures:

      i. Maximize alignment with the CT SIM quality scorecard

      ii. Include, at a minimum, the race/ethnicity categories identified in 1a. and preferred language.

      iii. Are quantifiable and address outcomes rather than process whenever possible.

      iv. Meet generally applicable principles of reliability, validity, sampling and statistical methods.

ii. ~~Include, at a minimum, Office of Management and Budget (OMB) race/ethnicity categories and preferred language in their EMR~~

Current language

Core Standard 2: Health Equity Improvement, Part 1

1. Expand the collection, reporting, and analysis of standardized data stratified by sub-populations

   d. 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**, and geography/place of residence**

   e. The network establishes methods of comparison between sub-populations.

      I. Clinical outcome and care experience measures are compared internally against the networks attributed population or to a benchmark

      II. Stratification by race/ethnicity/**language** is informed by the demographics of the population served by the network

Current language

Core Standard 2: Health Equity Improvement, Part 2, Introduction

- For the pilot, networks will be encouraged to focus on sub-populations defined by large race and ethnic populations and one of three conditions (diabetes, hypertension and asthma) that are included in the SIM Core Quality Measure set. The network may propose an alternative area of focus based on the network's demographics and performance data. Networks are encouraged to pilot the intervention in at least five practices or a large clinic setting.
- **The primary purpose of the intervention is to develop these skills with a focus sub-population and condition so that these same skills can then be applied to other sub-populations and conditions. It is expected that the Advanced Networks and FQHCs will examine their performance with smaller sub-populations such as Southeast Asian or Cambodian populations and adopt similar methods to close health equity gaps.**

Current language

Core Standard 2: Health Equity Improvement, Part 2, Introduction

- For the pilot, networks will be encouraged to focus on sub-populations defined by **race, ethnicity, and or language** and one of three conditions (diabetes, hypertension and asthma) that are included in the SIM Core Quality Measure set.
- **The primary purpose of the intervention is to develop these skills with a focus sub-population and condition so that these same skills can then be applied to other sub-populations and conditions. It is expected that the Advanced Networks and FQHCs will examine their performance with smaller sub-populations such as Southeast Asian or Cambodian populations and adopt similar methods to close health equity gaps.**

CCIP Draft 4 Public Comments Summary

A referral algorithm can be used to identify individuals who will benefit from CHW support

Proposed edit to HE.Part 2 Standard 3

Network identifies individuals who will benefit from CHW support by developing criteria that assess whether an individual:

i. Is part of the focus sub-population for the intervention

ii. Has a lack of health status improvement for the targeted clinical outcome

iii. Has cultural, health literacy and/or language barriers

iv. Has social determinant or other risk factors associated with poor outcomes

Network has a process that allows for automated referral to CHW based on above

CCIP Draft 4 Public Comments Summary

Other suggestions: Health Equity Intervention

- Require that the Community Health Worker is culturally appropriate for the community being served and is able to build trust with the population

CORE STANDARD 3: BEHAVIORAL HEALTH INTEGRATION

COMMENTS

CCIP Draft 4 Public Comments Summary

Suggestion: Clarify the strategy for individuals with identified chronic behavioral health needs

- The CCIP standard for integrating behavioral health identify processes to identify unidentified behavioral health needs in the primary care setting. The target population was chosen in order to avoid duplication of efforts focused on those with chronic behavioral health needs, such as behavioral health homes.

Proposed edit to Report:

- Add to the description section of the behavioral health section that coordinating care for those with identified chronic behavioral health needs is critical and expected of networks. Clarify that CCIP standards focus on unidentified needs and primary care coordinated interventions in order to avoid duplication with existing programs for higher risk individuals (e.g., DHMAS Behavioral Health Homes).

COMMUNITY COLLABORATIVES STANDARDS COMMENTS

CCIP Draft 4 Public Comments Summary

Other suggestions: Collaboratives

- Consider including a multi sector health collaboration and/or someone from philanthropy (e.g., RWJF)
- Consider the use of incentives to bring stakeholders such as healthcare providers from across the continuum of care (i.e., hospitals, LTSS, primary care practices, VNA/home health, FQHCs, specialists, behavioral health and dental providers, pharmacists, etc.) to bring them to the table

OTHER COMMENTS

CCIP Draft 4 Public Comments Summary

Concerns:

- **Could undermine drivers of current Medicaid success like the DSS PCMH and Intensive Care Management programs;**
- **Could cause duplication in efforts around care management, population risk identification, and community collaboration**
- **Only required of Medicaid participating providers**
- **Lack of evidence**
- **Prescriptive, overly burdensome on providers**

- SIM PMO has released a response to comments that address these concerns, and help clarify some of the CCIP standards and descriptions:

http://healthreform.ct.gov/ohri/lib/ohri/work_groups/practice_transformation/ccip_standards/ccip_response_to_concerns_summary_03152016_final.pdf

http://healthreform.ct.gov/ohri/lib/ohri/work_groups/practice_transformation/ccip_standards/ccip_response_to_concerns_03152016_final.pdf

CCIP Draft 4 Public Comments Summary

Proposed Edits to Report include:

- The CCIP report will be revised to emphasize the importance of supporting the best interests of Medicaid beneficiaries
- Will also incorporate relevant material from the “Response to Concerns” document into the report.

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Timeline

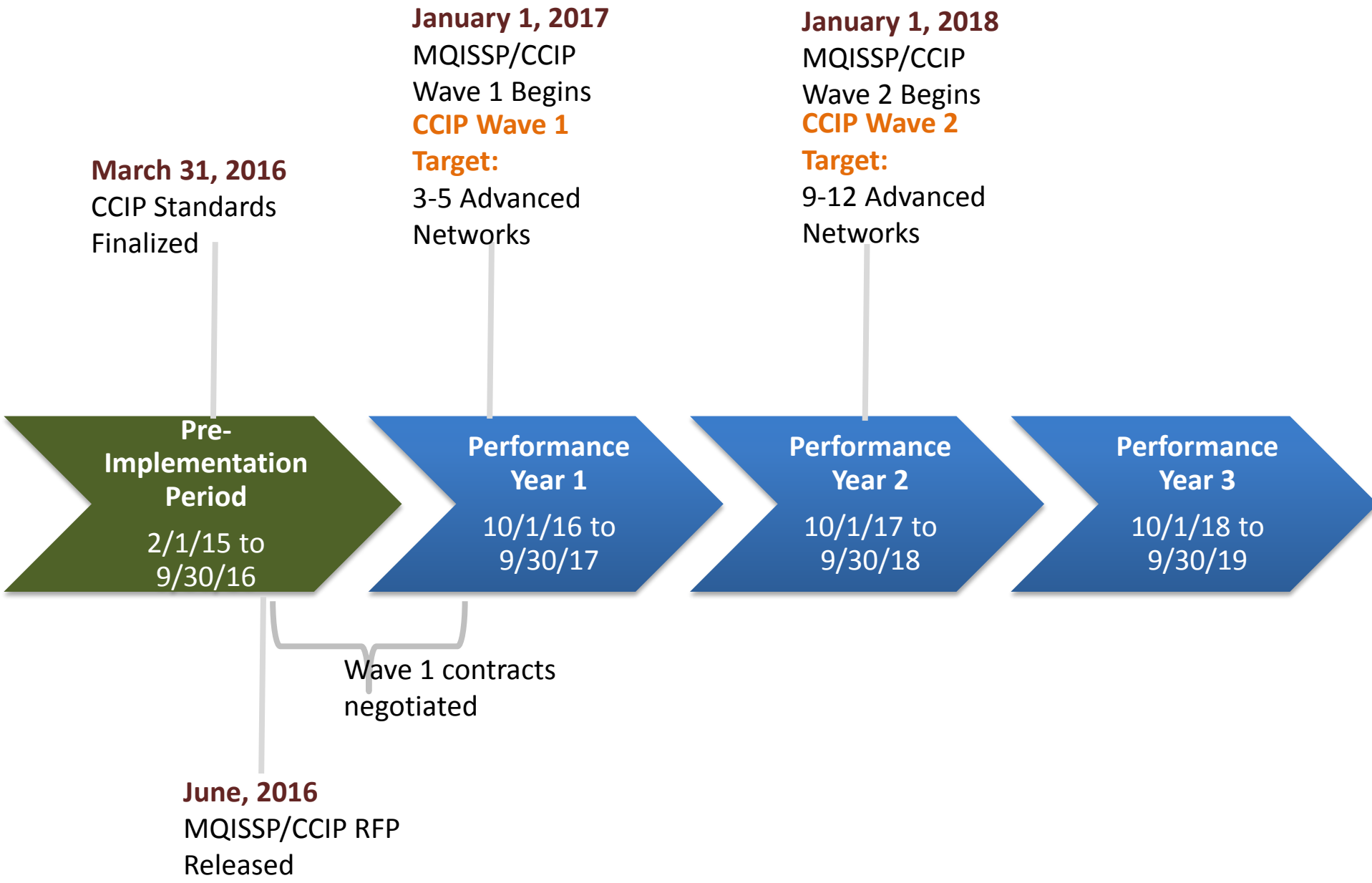
- Public comment closed March 2, 2016
- DSS and the PMO have prepared a response to concerns and a plan for coordinating the launch of MQISSP and CCIP
- The response and plan is summarized at:

  http://healthreform.ct.gov/ohri/lib/ohri/work_groups/practice_transformation/ccip_standards/ccip_response_to_concerns_summary_03152016_final.pdf

  http://healthreform.ct.gov/ohri/lib/ohri/work_groups/practice_transformation/ccip_standards/ccip_response_to_concerns_03152016_final.pdf

- Plan discussed with the following in March:
  - Medical Assistance Program Oversight Council, Care Management Committee
  - Practice Transformation Task Force
  - Healthcare Innovation Steering Committee
- Finalize CCIP standards by end of March 2016

CCIP Timeline



Next Steps

- Steering Committee meeting to present CCIP standards (3/30/16)
- Draft RFP to procure transformation vendor(s)