Connecticut State Innovation Model (SIM)

Report of the Practice Transformation Taskforce on

Community and Clinical Integration Program Standards

for Advanced Networks and Federally Qualified Health Centers

Elective Standards

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Community and Clinical Integration Program Core and Elective Standards

Contents

ELECTIVE STANDARD 1:

ORAL HEALTH INTEGRATION

Program Description and Objective:

Description: It is well documented that there is an oral-systemic link (Qualis Health, 2015). The oral health integration standards provides best-practice processes for the primary care practices to routinely perform oral health assessment with recommendation for prevention, treatment and referral to a dental home.

Objective: To improve oral for all populations with its associated impact on overall health. An individual's oral health affects their overall health and vice versa, in particular when individuals have certain chronic diseases such as diabetes, obesity, lung and heart diseases, as well as affected the birth outcomes. These standards put into primary care practices processes that promote treating the individual that acknowledges the oral-systemic link.

High Level Intervention Design:

1. **Screen individuals for oral health risk factors and symptoms of oral disease**
2. **Determine best course of treatment for individual**
3. **Provide necessary treatment – within primary care setting or referral to oral health provider**
4. **Track oral health outcomes/improvement for decision support and population health management**

1. **Screen individuals for oral health risk factors and symptoms of oral disease**
   a. The network develops a risk assessment[1] that will be reviewed by the primary care provider to screen all individuals for oral health needs using a tool that includes questions about:
      i. The last time the individual saw a dentist and the service received
      ii. Name of dentist and location/dental home if available[2]
      iii. Oral dryness, pain and bleeding in the mouth
      iv. Oral hygiene and dietary habits
      v. Need and expectations of the patient
   b. The network determines a process and protocol to administer the risk assessment that identifies:
      i. The format of the assessment (i.e.; written or verbal)
      ii. Who administers the assessment (can be anyone in the practice)
   c. The network identifies a process to flag individuals for follow-up for further evaluation and basic intervention that includes the primary care based preventive measures detailed in section two

[1] See Appendix F for a link to sample risk assessments

[2] A "dental home" means an ongoing relationship between a dentist and an individual, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated and person or family-centered way (reference: Connecticut Dental Health Partnership (CTDHP) Dental Home Definition)

d. The network develops an oral examination[3] procedure of the entire oral cavity that includes:
   i. Assessment for signs of active dental caries (white spots or untreated cavities)
   ii. Poor oral hygiene (presence of plaque, or gingival inflammation
   iii. Dry mouth (no pooling saliva and/or atrophic gingival tissues)
   iv. Lesions including pre-cancer and cancerous lesions.
e. The network determines who is responsible for conducting oral exam[4] and ensures appropriate oral health training and education is received by the care team members conducting the exam.

2. Determine best course of treatment for individual

a. The network designates care team member(s) to review the risk assessment and the oral exam with the individual[5]
b. The network develops a set of standardized criteria to determine the course of treatment that includes:
   i. Consideration for the answers on the risk assessment, findings from the oral exam, and individual preferences
   ii. Identification of which prevention activities can be provided in the primary care setting[6]

3. Provide necessary treatment – within primary care setting or referral to oral health provider

a. The network will determine who in the primary care setting is responsible for delivering preventive care[7]
   Training existing team members to provide the needed services (e.g., LPNs)
b. The networks provides prevention education and materials in the primary care setting, ideally by a trained health educator or care coordinator[8], that includes:
   i. Providing products that support oral hygiene if available (e.g., toothbrush, floss, etc.)[9]
   ii. Using the built in EMR tools that provide standardized education to the individual based on diagnosis

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[3] See Appendix F for sample Oral Exam

[4] The oral exam can be conducted by anyone on the care team who has received the proper oral health training and education, but Medicaid only reimburses for the exam if it is conducted by a PCP, APRN, or PA for children under 3. Currently in discussions with DSS to reimburse for a broader age range

[5] Any member of the care team can review findings of the assessment and the exam with the individual, but as a general rule the severity of the condition should dictate the level of the person who interacts with the individual (e.g., if there is a concern about oral cancer findings should be shared by a primary care provider, if a referral is needed it can be shared by another member of the team)

[6] The following prevention activities are usually provided in the primary care setting: changes to medication to protect the saliva, teeth, and gums; Fluoride varnish application whenever applicable or prescription for supplemental fluoride for children not drinking fluoridated water (information on fluoridated water testing: http://oralhealth.uchc.edu/fluoridation.html); dietary counseling to protect teeth and gums, and to promote glycemic control for individuals with diabetes; oral hygiene education and instruction; therapy for tobacco, alcohol and drug addiction

[7] Preventive care provided in the primary care setting can be provided by any member of the care team with the exception of changing medications which needs to be done by the primary care provider

[8] If a health educator or care coordinator is not available other members of the care team can be trained to provide education

[9] The CTDHP can be a resource for this – will provide dental referral information and may issue free oral health products for Medicaid patients https://www.ctdhp.com/ or 1-855-CT-DENTAL

iii. Providing educational messages on prevention that can be provided by all members of the care team in the absence of a health educator or care coordinator
iv. Providing written materials such as a handout in the waiting room or an after visit summary as supplemental education

c. The network develops a process and protocols to make, manage, and close out referrals that include:
   i. Identifying a preferred dental network for referrals for individuals who do not have a usual source of dental care[10]
   ii. Coordinating to share the necessary health information with the individual's dental network which includes:
      1) Individual's problem list
      2) Current medication, allergies, and health conditions.
      3) Reason for the referral
      4) Confirmation that the individual is healthy enough to undergo routine dental procedures
   iii. Confirming the individual made an appointment with the dentist and the date of the appointment
   iv. Requesting a summary of the dentist's findings and treatment plan upon completion of the dental visit for inclusion in the individual's health record
   v. Developing technology solutions for sharing necessary information between primary care providers and dental providers[11]
   vi. Designating an individual to be responsible for tracking and coordinating referrals, confirming that the dental appoint was made, occurred, and the agreed upon material was shared between providers
   vii. Providing additional support services where/when possible (i.e.; transportation, interpretation, etc.)

4. Track oral health outcomes/improvement for decision support and population health management

a. The networks electronically captures the following items[12]:
   i. Risk assessment results
   ii. Oral risk assessment and screening results
   iii. Interventions received: referral order, preventions in clinic
   iv. Documentation of completed referral
b. The network monitors and reports on integration process that supports quality improvement and holding the primary care and dental partners accountable to the established agreements

[10] Medicaid patient and locations of safety-net facilities, contact CTDHP at 1-855-CT-DENTAL or https://www.ctdph.com.

[11] Networks should consider technologies such as direct messaging or secure messaging

[12] Networks should consider capturing data in a structured manner (i.e.; delimited fields vs free text) so data can easily be tracked for reporting purposes

ELECTIVE STANDARD 2:

ELECTRONIC CONSULTATION (E-consults)

Program Description and Objective:

Description: E-consults is a telehealth system in which Primary Care Providers (PCPs) consult with a specialist reviewer electronically via e-consult prior to referring an individual to a specialist for a face to face non-urgent care visit. This service can be made available to all individuals within the practice and for all specialty referrals, but may be more appropriate for certain types of referrals such as cardiology and dermatology. E-consult provides rapid access to expert consultation. This can improve the quality of primary care management, enhance the range of conditions that a primary care provider can effectively treat in primary care, and reduce avoidable delays and other barriers (e.g., transportation) to specialist consultation.

Objective: Improve timely access to specialists, improve PCP and specialist communication, and reduce downstream costs through avoiding unnecessary in-person specialist consultations.

High-Level Intervention Design:

1. **Identify individuals eligible for e-consult**
2. **Primary care provider places e-consult to specialist provider**
3. **Specialist determines if in person consult is needed or if additional information is needed to determine the need for in person consult**
4. **Specialist communicates outcome back to primary care provider**

1) Identify individuals eligible for e-consult

a) The network defines for which specialty they will do e-consults[13]

b) The network involves the individual in the decision to utilize an e-consult and will send e-consults for all individuals who require the service of the designated specialty and who assent to e-consult, with the exception of individuals with urgent conditions and those who have a pre-existing relationship with a specialist

2. Primary care provider places e-consult to specialist provider

a. The network designates with which specialty practice or specialty providers it will coordinate e-consults[14].

[13] Policy reports done in Connecticut by UCONN and Medicaid explored the use of e-consults for Cardiology, Dermatology, Gastroenterology, Neurology, Orthopedics and Urology (http://www.publichealth.uconn.edu/assets/econsults_ii_specialties.pdf; http://www.publichealth.uconn.edu/assets/econsults_cardiology.pdf)

[14] If the network does not have specialists in their network, they may want to consider establishing an e-consult relationship with a set of designated specialist providers who are distinct from the specialty providers who would do the face to face consult. This will promote neutral decision making on the part of the specialist by eliminating the financial incentive to suggest a face to face visit. If the specialists are within the same network, this will not be necessary.

b. In partnership with the specialty practice and/or providers, the network develops a standardized referral form that includes:
    i. Standard form text options to ensure important details are shared
    ii. Free text options to the opportunity for the primary care provider to share additional details of importance (Kim-Hwang JE, 2010)
    iii. The ability to attach images or other information that cannot be shared via form or free text
c) The network in partnership with the specialty practice develops a technology solution to push e-consults to the specialty practice and/or providers designated to do e-consults[15]
d) The network develops a process and protocol to send e-consults to the designated specialty practice and/or providers that includes:
    i) Identifying an individual in the primary care practice responsible for sending the e-consult to the specialty practice and/or providers
    ii) Setting a timeframe within which the e-consult should be sent post-primary care visit
    iii) Establishing a payment method for the e-consult service[16]
e) The specialty practice and/or provider develops a process and protocol to receive and review the e-consult that includes:
    i) Identifying a coordinator whose responsibility it is to receive and prepare the consult for review
    ii) Setting a timeframe within which the e-consult has to be reviewed once received by specialty practice

3) Specialist determines if in-person consult is needed or if additional information is needed to determine the need for in-person consult

The specialist triages the referral into one of three categories:
i) The individual does not need a referral
ii) The individual may need a referral but additional information is needed from the primary care provider (i.e.; additional history, additional tests run, etc.)
iii) The individual needs an in-person visit

4) Specialist communicates outcome back to primary care provider

The network in collaboration with the specialty practice develops processes and protocols for primary care and individual notification of e-consult outcomes that include:
i) Setting a timeframe within which the specialist notifies the primary care practice of e-consult result regardless of the outcome
ii) Providing communication back to the primary care provider in the form of a consult note with information on how to handle the issue in the primary care setting when a consult is not needed
iii) Identifying how the primary care provider will notify the individual that follow-up is needed and process for scheduling additional testing, if necessary
iv) Identifying how the primary care practice will connect the individual to referral coordination services to schedule the visit, to confirm that a visit was scheduled and to ensure the

[15] Solutions will vary based on available technology to both primary care providers and specialists. Range of solutions include: faxing, secure messaging, direct messaging, EMR based solution

[16] Currently Medicaid has limited reimbursement for e-consults. Additional exploration around expanded reimbursements is being investigated

necessary information from the specialist is shared with the primary care provider from the in-person consultation

ELECTIVE STANDARD 3:

COMPREHENSIVE MEDICATION MANAGEMENT

Program Description and Objective:

Description: The Comprehensive Medication Management (CMM) intervention will be an elective CCIP capability for patients with complex therapeutic needs who would benefit from a comprehensive personalized medication management plan. CMM is a system-level, person-centered process of care provided by credentialed pharmacists to optimize the complete drug therapy regimen for a patient's given medical condition, socio-economic conditions, and personal preferences. The CMM evidence-based model was approved by 11 national pharmacy organizations and is dependent upon pharmacists working collaboratively with physicians and other healthcare professionals to optimize medication use in accordance with evidence-based guidelines.[17] In the context of CCIP, the CMM intervention will be relevant for all patients who are experiencing difficulty managing their pharmacy regimen, who have complicated or multiple drug regimens, or who are not experiencing optimal therapeutic outcomes; this includes patients enrolled in CCIP with complex conditions and patients experiencing equity gaps.

Objective: To assure safe and appropriate medication use by engaging patients, caregivers/family members, prescribers, and other health care providers to improve medication-related health outcomes.

High-Level Intervention Design:

1. **Identify patients requiring comprehensive medication management**
2. **Pharmacist consults with patient/caregiver in coordination with PCP or comprehensive care team**
3. **Develop and implement a person-centered medication action plan**
4. **Follow-up and monitor the effectiveness of the medication action plan for the identified patient**

1. **Identification of patients requiring comprehensive medication management**
   a. The network defines criteria to identify patients with complex and intensive needs related to their medication regimen that would be conducive to pharmacist intervention[18];
   b. The network develops a process for the responsible professional and/or care team to assess patient medication management needs[19]

[17] Joint Commission of Pharmacy Practitioners. *Pharmacists' Patient Care Process.* May 29, 2014. https://www.accp.com/docs/positions/misc/JCPP_Pharmacists_Patient_Care_Process.pdf

[18] Characteristics of patients with these needs could include patients with: multiple chronic conditions, complicated or multiple medication regimens, failure to achieve treatment goals, high risk for adverse reactions, preventable utilizations due to difficulty managing medication regimens (e.g. hospital admissions, readmissions, emergency department, urgent care, and/or physician office visits), health equity gaps, multiple providers, functional deficits (e.g. swallowing, vision, and mobility problems), and multiple care transitions

[19] This assessment should occur at the time of the person-centered assessment for patients who are part of the CCIP Complex Care population. Other patients in need of additional medication management who are not part of CCIP can be identified/referred by other members of the care team or through automated triggers based on EHR-

2. **Pharmacist consults with patient and, if applicable, caregiver in coordination with PCP or comprehensive care team**
    a. The Advanced Network or FQHC selects a pharmacist integration model that aligns with their current network needs/current state.[20]
        i. Regardless of the model, the pharmacist should have direct care experience and pharmacist credentials are reviewed[21] [22]
        ii. The pharmacist will be trained to access the patient's EHR and comprehensive care plan, and any network-specific workflows, as needed.
    b. The pharmacist conducts the initial patient consult in person[23].
3. **Develop and implement a person-centered medication action plan**
    a. The pharmacist develops an action plan during the initial patient consultation in partnership with the patient and/or caregivers[24]
    b. To develop the person-centered medication action plan the pharmacist will:
        i. Create a comprehensive list of all current medications the patient is taking including prescribed medications, nonprescription/over-the-counter medications, nutritional supplements, vitamins, and herbal products. Assess each medication for appropriateness, efficacy, safety, and adherence/ease of administration given a patient's medical condition and co-morbidities.
        ii. This assessment will be person-centered and also take into account the compatibility of medication with the individual's cultural traditions, personal preferences and values, home or family situation, social circumstances, age, functional deficits, health literacy, medication experiences and concerns, lifestyle, and financial concerns including affordability of medications compared to other regimens that achieve the same medical goals.
    c. The person-centered medication action plan includes:

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programmed "alert" claims or EHR-based analytic reports. The assessment should include patient preferences and concerns.

[20] Possible models include: (1) pharmacist is a clinician staff member of the practice; (2) pharmacist is embedded in the practice site through a partnership between the practice and another entity (e.g., hospital, school of pharmacy, etc.); (3) regional model by which the pharmacist works for a health system and serves several practices in a geographic area; and (4) shared resource network model by which the pharmacist is contracted by a provider group, ACO, or payer to provide services to specific patients

[21] Pharmacist should have some experience in a direct patient care role, and training should occur at on-boarding with additional team based training as needed (i.e.; new team members join, protocols change, etc.) and annual validation of credentials.

[22] Networks should determine the appropriate credentials for CMM services. CT has addressed pharmacist competencies with a State regulation for Collaborative Drug Therapy Management (CDTM), which includes interdisciplinary, team-based, patient-centered care. It is recommended that networks adopt the CDTM competencies language as minimum credentials for pharmacists providing CMM services. The CDTM regulation can be found here: http://www.healthreform.ct.gov/ohri/lib/ohri/work_groups/practice_transformation/reference_library_/ct_cdtm_regs_2012.pdf.

[23] For patients participating in the CCIP Complex Care program, this consult should occur in conjunction with the initial comprehensive care team person-centered assessment and/or care planning meeting, while other patients should schedule a consult with the pharmacist within a specified timeframe post-identification of the need for CMM. Once a patient is making good progress toward meeting the goals of a medication action plan, or for less complex patients, telehealth or telephonic, or other touch points may be advisable.

[24] In the CMM process every patient receives an action plan regardless of whether or not it is requested by the patient/caregiver.

i. An updated and reconciled medication list with information about medication use, allergies, and immunizations.
ii. Education and self-management training to engage patients and their caregivers on better techniques to achieve self-management goals and adhere to the medication regimen.
iii. The patient's treatment goals and pharmacist's actionable recommendations for avoiding medication errors and resolving inappropriate medication selection, omissions, duplications, sub-therapeutic or excessive dosages, drug interactions, adverse reactions and side effects, adherence problems, health literacy challenges, and regimens that are costly for the patient and/or health care system; pharmacist's recommendations are communicated to patients, caregivers, primary care provider, and other health care providers as needed.
iv. An outline of the duration of the CMM intervention; frequency of interactions between pharmacist and patient throughout the CMM intervention; and instructions on follow-up with the pharmacist, comprehensive care team, primary care team, and specialists as needed[25].
v. Coordination of care, including the referral or transition of the patient to another health care professional.

d. The person-centered medication action plan becomes a part of the patient's medical record
The network develops a process or protocol to make the person-centered medication plan accessible to all necessary care team members. The process or protocol will include:
1) Identifying who needs to have access to the person-centered medication action plan, which at a minimum will include the pharmacist and primary care provider but which should also be guided by patient preference and the team needs assessment[26].
2) Developing technological capabilities for specified individuals to have access to the person-centered medication action plan

4. Follow-up and monitor the effectiveness of the medication action plan for the identified patient.

a. Pharmacist monitors and evaluates the effectiveness of the care plan and modifies the plan in collaboration with other health care professionals and the patient or caregiver as needed. This process includes the continuous monitoring and evaluation of:
i. Medication appropriateness, effectiveness, and safety and patient adherence through available health data, biometric test results, and patient/caregiver/primary care provider feedback.
ii. Clinical endpoints that contribute to the patient's overall health.
iii. Outcomes of care, including progress toward or the achievement of goals of therapy.

b. Schedule follow-up care as needed to achieve goals of therapy.
The pharmacist and care team initiate follow-up care processes to schedule touchpoints with the patient and/or caregiver as outlined in the person-centered medication action plan[27]
1) The pharmacist participates in the comprehensive care team meetings if the patient is also participating in the CCIP complex patient intervention.
2) The pharmacist and care team define a process to monitor and revise the person-centered medication action plan as necessary after follow up visits with the care team.

[25] Patient with more complex needs may require more frequent follow-up with the pharmacist and care teams. The plan should identify the format for touch points, which should be guided by patient preference and the team needs assessment. Some formats include in-person, telephonic, and other telehealth mediums.
[26] If the patient has a comprehensive care team or is working with a Community Health Worker, those individuals should also have access.
[27] Other care team members who are part of the implementation plan are identified through the consultation process. The touch points should align with those identified in the person-centered medication action plan for those patients who are participating in the CCIP complex care management intervention.