

CONNECTICUT HEALTHCARE INNOVATION PLAN



**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**

Core and Elective Standards

March 2016

Community and Clinical Integration Program Core and Elective Standards

Contents

- CORE STANDARD 1: COMPREHENSIVE CARE MANAGEMENT 3
- CORE STANDARD 2: HEALTH EQUITY IMPROVEMENT..... 9
 - PART 1: CONTINUOUS QUALITY IMPROVEMENT STANDARDS 9
 - PART 2: HEALTH EQUITY INTERVENTION PILOT 12
- CORE STANDARD 3: BEHAVIORAL HEALTH INTEGRATION..... 16
- ELECTIVE STANDARD 1: ORAL HEALTH INTEGRATION..... 19
- ELECTIVE STANDARD 2: ELECTRONIC CONSULTATION (E-consults) 22
- ELECTIVE STANDARD 3: COMPREHENSIVE MEDICATION MANAGEMENT 25

CORE STANDARD 1:

COMPREHENSIVE CARE MANAGEMENT (CCM)

FOCUS POPULATION: INDIVIDUALS WITH COMPLEX HEALTH CARE NEEDS

Individuals with Complex Health Care Needs: Individuals who have one or more serious medical conditions, the care for which may be complicated by functional limitations or unmet social needs, and who require care coordination across different providers, community supports and settings to achieve positive healthcare outcomes.

Program Description and Objective:

Description: Complex care management is a person-centered process for providing care and support to individuals with complex health care needs. The care management is provided by a multi-disciplinary *comprehensive care team* comprised of members of the primary care team and additional members, the need for which is determined by means of a person centered needs assessment. The comprehensive care team will focus on further assessing the individual's clinical and social needs, developing a plan to address those needs, and creating action steps so that the individual is both directing and involved in managing their care.

The standards for comprehensive care management are intended to supplement existing medical home and care coordination programs in Connecticut. The standards will enable medical homes to identify more effectively individuals who would benefit from comprehensive care management, engage those individuals in self-care management, and coordinate services by means of expanded care team that includes community-based service and support providers. The comprehensive care management process may introduce additional components to the individual's care plan, which will be coordinated as the individual progresses through the program. The ability of participating providers to meet the standards through existing programs vs. the need to develop supplemental capabilities, will be determined by means of a readiness review or gap analysis conducted with the assistance of the transformation vendor at the start of the program.

Objective: The objective is to comprehensively address identified barriers to care and healthy living and engage the individual directly in the direction and management of their care.

High-Level Intervention Design:

1. Identify individuals with complex health care needs
2. Conduct person-centered assessment
3. Develop an individualized care plan
4. Establish a comprehensive care team
5. Execute and monitor the individualized care plan

Person-Centered Definition: Person-centered care engages patients as partners in their healthcare and focuses on the individual's choices, strengths, values, beliefs, preferences, and needs to ensure that these factors guide all clinical decisions as well as non-clinical decisions that support independence, self-determination, recovery, and wellness (quality of life). The individual engages in a

- 6. Identify whether individuals are ready to transition to self-directed care maintenance and primary care team support**
- 7. Monitor individuals to reconnect to comprehensive care team when needed**
- 8. Evaluate and improve the effectiveness of the intervention**

1. Identify individuals with complex health needs

- a. 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 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.
- b. The network has a process to electronically alert the medical home care team of the identified individuals with complex health needs that meet or exceed risk thresholds.

2. Conduct person-centered assessment

- 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 (spoken and written)
 - ii. Family/social/cultural characteristics including sources of support
 - iii. Assessment of health literacy
 - iv. Social determinant risks
 - v. Personal preferences, values, needs, and strengths
 - vi. Assessment of behavioral health needs, inclusive of mental health, substance abuse, and trauma
 - vii. Functional assessment
 - viii. Reproductive health needs
 - ix. The primary and secondary clinical diagnoses that are most challenging for the individual to manage
- b. Network defines processes and protocols for the conduct of a person-centered needs assessment that defines:
 - i. Where the person-centered needs assessment takes place
 - ii. The timeframe within which the person-centered needs assessment is completed
 - iii. The appropriate staff member to conduct the initial assessment

3. Develop an individualized care plan

- a. The comprehensive care team including the individual and their natural supports¹ collaborate to develop the individualized care plan² 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

¹ Natural supports include but are not limited to, family, clergy, friends, and neighbors

² See Appendix F for examples of person-centered care coordination plans

- iv. Identifies referrals necessary to address clinical and social health goals and a plan for linkage and coordination
- b. The network defines a process and protocol for the comprehensive care team to create the individualized care plan including location, timeframe for completion, the lead team member responsible for creating the care plan, and frequency of follow-up meetings to update the care plan, if needed

4. Establish a comprehensive care team

- a. The network develops a comprehensive care team capability that specifically addresses the individual needs of the patient in accordance with the individualized care plan
- b. The network implements a process to connect individuals to a comprehensive care team such as:
 - i. During the primary care visit
 - ii. During an ED visit or inpatient hospital stay
 - iii. Pro-actively reaching out to the individual identified through analytics or registry data³
- c. 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.
- d. The network ensures that each care team:
 - i. 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.
 - ii. has the capability to add a community health worker to fulfill community-focused coordination functions
 - iii. 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
 - iv. adds comprehensive care team members outside of the above core functions (e.g., dietitians, pharmacists, palliative care practitioners, etc.) on an as needed basis depending on the needs identified in the person-centered assessment
- e. The network ensures that practices have a documented policy and procedure for integrating additional comprehensive care team members. Options include:
 - i. Contracted or employed staff that reside within each primary care practice or in one or more hubs that support multiple practices
 - ii. Coordination protocols for integrating affiliated clinical staff (e.g., specialists)
 - iii. Contracted support from community organizations (e.g., CHW staff)
 - iv. Collaborative agreements with clinical partners (e.g., home care)
- f. The network establishes the appropriate case load (patient to team ratio) for comprehensive care teams based on local needs
- g. The network establishes training protocols related to:
 - i. Identifying values, principles and goals of the comprehensive care team intervention

³ Experience in other states suggest that the individual who is pro-actively reaching out to individuals should be someone they identify with and who can build rapport with them (e.g., a peer support or CHW) (Center for Healthcare Solutions, 2015)

- ii. Re-designing the primary care workflows that to integrate the comprehensive care team work processes
- iii. Orienting the primary care team to the roles and responsibilities of the additional care team members that form the comprehensive care team
- iv. Basic behavioral health training appropriate for all comprehensive care team members
- v. Motivational interviewing (required for the care coordinator, recommended for other primary care team members as appropriate)
- vi. 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
- h. 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
- i. The network develops and administers CHW training protocols or ensures that CHWs have otherwise received such training:
 - i. Person-centered assessment
 - ii. Outreach methods and strategies
 - iii. Effective communication methods
 - iv. Motivational interviewing
 - v. Health education for behavior change
 - vi. Methods for supporting, advocating and coordinating care for individuals
 - vii. Public health concepts and approaches⁴
 - viii. Community capacity building (i.e.; improving ability for communities to care for themselves) (Boston, 2007)
 - ix. Maintaining safety in the home
 - x. Basic behavioral health training to enable recognition of behavioral health needs

5. Execute and monitor individualized care plan

- a. The network establishes protocols for regular comprehensive care team meetings that establish:
 - i. Who is required to attend⁵
 - ii. The frequency of the meetings
 - iii. The format of the meetings (i.e.; via conference call, in person, etc.)
 - iv. A standardized reporting form on the individual's progress and risks
- 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. The protocol includes:
 - i. Establishing key touch points for monitoring and readjusting the individualized care plan, as necessary
 - ii. Establishing who from the comprehensive care team will be involved in the touch points
 - iii. Developing a standardized progress note that documents key information obtained during the touch points

⁴ This includes common public health trends including the social determinants of health as well as awareness of conditions that are frequently unaddressed including reproductive health, oral health, behavioral health, etc.

⁵ Best practice suggests all members of the comprehensive care team and relevant primary care team members

- iv. Engaging the individual patient and caregivers in a plan to meet self-directed care management goals
 - c. The network modifies its process for exchanging health information across care settings to accommodate the role and functions of the comprehensive care team
 - Establishing the necessary agreements with providers with whom information will be exchanged, identifying the type of information to be exchanged, timeframes for exchanging information, and how the organization will facilitate referrals
 - d. The network establishes a technology solution and/or protocols with local hospital and facility partners to alert the primary care provider and comprehensive care team when a patient is admitted or discharged from an ED, hospital, or other acute care facility to support better care coordination and care transitions
 - e. The network establishes a process and protocols for accessing an up-to-date resource directory (such as United Way 211), connecting individuals to needed community resources (i.e.; social support services), tracking referrals, and tracking barriers to care, and providing facilitation to address such barriers (i.e., rides to appointments).
- 6. Identify when the individual is ready to transition to self-directed care maintenance and primary care team support**
- a. The network has a process for the comprehensive care team to collaborate with the individual to assess readiness to independently self-manage and transition to routine primary care team support⁶
 - b. The process includes examination of options to connect the individual to ongoing community supports such as a peer support resource
- 7. Monitor individuals to reconnect to comprehensive care team when needed**
- a. The network establishes a mechanism to:
 - i. monitor and periodically re-assess transitioned individuals (ideally every 6-12 months)
 - ii. notify the comprehensive care team when the individual has a change of condition or circumstances that require a reconnection to the comprehensive care team⁷
- 8. Evaluate and improve the effectiveness of the intervention**
- a. The network demonstrates that the comprehensive care team is improving healthcare outcomes and care experience for complex individuals by:
 - i. Tracking aggregate clinical outcome, individual care experience, and utilization measures that are relevant to the focus population's needs (i.e.; complex individuals)⁸
 - ii. Achieving improved performance on identified measures
 - b. The network identifies opportunities for quality process improvement. This will require:
 - i. Defining process and outcome measures specific to the comprehensive care team intervention
 - ii. Developing training modules for the care team, community supports, and patients/families

⁶ See Appendix F for sample tool

⁷ The network could consider utilizing a ED/Inpatient admission/discharge alert technology for monitoring

⁸ Clinical measure and experiences measures for complex individuals should be determined based on the most prevalent clinical areas of need for the network's complex individuals (e.g., behavioral health) and lower performing experience measures; utilization measures will likely include inpatient admissions for ambulatory sensitive conditions, readmissions, and ED utilization

- iii. Establishing a method to share performance⁹ data regularly with comprehensive care team members and other relevant care providers to identify opportunities for improvement
- iv. Conducting root cause analyses for to understand and address areas of under-performance using clinical data and input from the focus population¹⁰
- c. The network implements at least one additional network capability to support the comprehensive care team process.

⁹ Performance is commonly shared through a dashboard or scorecard. Networks should also consider establishing learning collaboratives that bring together the different practices in their network to share best practices

¹⁰ Input can be solicited in a number of ways, including, but not limited to a community advisory board, a focus group, existing community meetings or community leadership

CORE STANDARD 2:

HEALTH EQUITY IMPROVEMENT

PART 1: Continuous Quality Improvement Standards

FOCUS POPULATION: INDIVIDUALS EXPERIENCING EQUITY GAPS

INTRODUCTION

The Health Equity Improvement standards are divided into two parts. Part 1 focuses on the continuous equity gap improvement including the analytic capabilities to routinely identify disparities in care, conduct root cause analyses to identify the best interventions to address the identified disparities, and develop the capabilities to monitor the effectiveness of the interventions. These standards also require that the organization undertake a pilot health equity improvement intervention. The standards contained in Part 2 specify an intervention that utilizes the support of a community health worker (CHW) to address equity gaps. CHWs are a component of the pilot intervention because research has demonstrated that they can be effective and because their integration in the care process presents special challenges that the technical assistance process is intended to address.

Program Description and Objective:

Description: Continuous quality improvement standards are intended to provide a standardized process for networks to use data to identify and address healthcare disparities.

Objective: Provide Advanced Networks and Federally Qualified Health Centers (FQHCs) with a set of data/analytic standards that will enable them to identify disparities in care on a routine basis, prioritize the opportunities for reducing the identified disparities, design and implement interventions, scale those interventions across networks, and evaluate the effectiveness of the intervention.

High-Level Intervention Design:

1. **Expand the collection, reporting, and analysis of standardized data stratified by sub-populations**
 2. **Identify and prioritize opportunities to reduce a healthcare disparity**
 3. **Implement a pilot intervention to address the identified disparity**
 4. **Evaluate whether the intervention was effective**
 5. **Other organizational requirements**
-
1. **Expand the collection, reporting, and analysis of standardized data stratified by sub-populations**
 - a) The network implements a plan to collect additional race and ethnicity categories for its patient population. The selection of additional 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

- b) It is recommended that the network also implements a strategy to routinely collect information regarding sexual orientation and gender identity.
- 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.
- c) The network analyzes the identified clinical performance and care experience measures stratified by race/ethnicity, language, other demographic markers such as sexual orientation and gender identity, and geography/place of residence.
- d) 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 benchmark¹¹
 - ii. Stratification by race/ethnicity/language is informed by the demographics of the population served by the network
- e) The 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 gaps

2. Identify and prioritize opportunities to reduce healthcare disparities

- a) The network documents and makes available to the technical assistance vendor the results of the opportunities identified through data analysis
- b) The network develops a process to prioritize opportunities. Prioritization considers:
 - Significance to individuals in the sub-population experiencing a disparity in care, which is evaluated through engaging members of the sub-population to prioritize opportunities

3. Implement at least one intervention to address the identified disparity (see Part 2)

- a) The network conducts a root cause analysis for the disparity identified for intervention and develops an intervention informed by this analysis
- b) 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
- c) The network designs a pilot intervention and describes how the intervention will meet the needs/barriers identified in the root cause analysis
- d) The network involves members of the sub-population who are experiencing the identified disparity in the design of the interventions
- e) The network implements an intervention in at least five practices

4. Evaluate whether the intervention was effective

¹¹ Networks not performing well against a national/regional benchmark may want to consider starting by comparing internally while networks with little disparity between in-network sub-populations may benefit from utilizing a benchmark.

- 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
- b) Identify opportunities for quality and process improvement. This will require:
 - i. Defining process and outcome measures for the interventions pursued
 - ii. Establishing a method to share performance¹² regularly with relevant care team participants to collectively identify areas for improvement

5. Other Organizational Requirements

- a) The network establishes culturally and linguistically appropriate goals, policies and management accountability, and infuses them throughout the organizations' planning and operations
- b) The network informs all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing
- c) The network ensures the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided

¹² Performance is commonly shared through a dashboard or scorecard. Networks should also consider establishing learning collaboratives that bring together the different practices in their network to share best practices

CORE STANDARD 2:

HEALTH EQUITY IMPROVEMENT

PART 2: HEALTH EQUITY INTERVENTION PILOT

Program Description and Objective:

Description: The health equity pilot intervention will focus on:

- Identifying social, cultural and health literacy factors that might compromise health care engagement, experience and outcomes
- Standardizing elements of the care processes to be more culturally and linguistically appropriate such as by producing translated and culturally appropriate educational materials
- Using a community health worker who has culturally and linguistically sensitive training to educate individuals about their condition, empower them to better manage their own care, and providing community focused care coordination to link individuals to needed social services and supports
- Re-engineering processes to optimize performance and minimize sub-population specific barriers in the care pathway

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 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.

Objective: Narrow the gap in identified health care outcome and maintain improvement. Use the services of a community health worker to support the initial improvement and long-term maintenance of health outcomes for the sub-population identified through the provision of culturally sensitive medical education about their condition, behavior change education to promote a healthy lifestyle, and identifying and connecting the individual to needed support services.

High-Level Health Equity Gap Intervention Design:

1. **Create a more culturally and linguistically sensitive environment**
2. **Establish a CHW capability**
3. **Identify individuals who will benefit from CHW support**
4. **Conduct a person-centered needs assessment**
5. **Create a person-centered self-care management plan**
6. **Execute and monitor the person-centered self-care management plan**

7. Identify process to determine when an individual is ready to transition to self-directed maintenance

1. Create a more culturally and linguistically sensitive environment

The identified practices provide culturally and linguistically appropriate services informed by the root-cause analysis conducted in relation to 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 individuals that comprise the focus population

2. Establish a CHW capability

- a. The network determines the best strategy for incorporating community health workers and community health worker field supervisor(s) into the primary care practices. Options include:
 - i. Employ the CHWs/CHW field supervisor within the practice
 - ii. Employ the CHWs/CHW field supervisor at one or more hubs in support of multiple practices
 - iii. Contract with community organizations for CHW/CHW field supervisor services
- b. The network documents process for how CHWs will be made available to individuals identified for the intervention
- c. The network establishes the appropriate case load for the CHW
- d. The network establishes training protocols on:
 - i. Identifying values, principles, and goals of the CHW intervention
 - ii. Redesigning the primary care workflow to integrate the CHWs work process
 - iii. Orienting the primary care team to the roles and responsibilities of the community health worker
- e. The network ensures training is provided:
 - i. To all primary care team members involved in the CHW intervention
 - ii. On an annual basis to incorporate new concepts and guidelines and reinforce initial training
- f. The network develops and administers CHW training protocols or ensures that CHWs involved in the intervention receive or have received disease-specific training based on the intervention, in addition to the core competency training outlined in CCM standard.

3. Identify individuals who will benefit from CHW support

- a. Network identifies individuals who will benefit from CHW support by developing criteria that assesses 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
- b. Network has a process to electronically alert the medical home care team of the identified individuals that meet criteria for health equity intervention.

4. Conduct a person-centered needs assessment

- a. To understand the historical and current clinical, social and behavioral needs of the individual, the network conducts a person-centered needs assessment with individuals identified for the intervention. The assessment includes:

- i. Preferred language
 - ii. Family/social/cultural characteristics
 - iii. Behaviors affecting health
 - iv. Assessment of health literacy
 - v. Social determinant risks
 - vi. Personal preferences and values
- b. Network defines the process and protocols for the CHW to conduct the person-centered needs assessment¹³

5. Create a person-centered self-care management plan

- a. The CHW and the individual and their natural supports¹⁴ collaborate to develop a self-care management plan based on the results of the person centered assessment. The care plan includes the following features:
- i. Incorporates the individual’s values, preferences and lifestyle goals
 - ii. Establishes health behavior goals that will improve self-care management and are reflective of the individual’s stage of change¹⁵
 - iii. Establishes social health goals that will improve self-care management and are reflective of needs/barriers identified in the person-centered needs assessment
 - iv. Identifies actions steps for each goal and establishes a due date¹⁶
- b. The network defines a process and protocols for the CHW to create the person-centered self-management plan including location and timeframe for completion¹⁷

6. Execute and monitor the self-care management plan

- a. The network establishes protocols for regular care team meetings that establish:
- i. Who is required to attend¹⁸
 - ii. The frequency of meetings
 - iii. The format for the meetings (i.e.; via conference call, in person, etc.)
 - iv. A standardized reporting structure on the individual’s progress and risks¹⁹
- b. The network establishes protocols for monitoring individual progress on the self-care management plan the includes:
- i. Establishing key touch points with the individual for monitoring and readjusting of the person-centered self-care management plan, as necessary
 - ii. Establishing who, in addition to the CHW, will be involved in the touch points

¹³ Should identify where the person-centered needs assessment should be conducted which should be determined by the patient and the timeframe within which it should be completed post CHW intervention enrollment

¹⁴ Natural supports include but are not limited to, family, clergy, friends, and neighbors

¹⁵ Stage of change refers to the Prochaska’s stages of change model that categorizes how ready an individual is to change their behavior. Stages include: pre-contemplation (not ready), contemplation (getting ready), preparation (ready), action, and maintenance

¹⁶ See Appendix F for examples from other programs

¹⁷ The network should determine where the self-care management plan should be completed which should be determined by the patient and a timeframe for completion post needs assessment should be established

¹⁸ Best practice suggests the following attendees: CHW, CHW field supervisor, key members of the primary care team, including the primary care provider

¹⁹ The intention of this report is to provide the team with an update, but also to alert the team to any key areas of concern that the broader team might be able to address

- iii. Developing a standardized progress not that documents key information obtained during the touch points
- c. The network modifies its process for exchanging health information across care settings to accommodate the role and functions of the CHW support²⁰
- d. The network develops a process and protocols for connecting individuals to needed community services (i.e. social support services)

7. Identify process to determine when an individual is ready to transition to self-directed maintenance

The network develops criteria to evaluate when the individual has acquired the necessary education and self-care management skills to transition to self-directed maintenance that includes:

- i. Collaborating with the individual to assess their readiness to independently self-manage their care
- ii. Assessing improvement on the relevant clinical outcomes
- iii. Assessing achievement of individual identified care goals

²⁰ The network should have agreements with necessary care providers about exchanging information; establish the type of information to be shared (consider needs assessment self-care management plan and patient progress notes ;timeframes for exchanging information; and, how the organization facilitates referrals

CORE STANDARD 3:

BEHAVIORAL HEALTH INTEGRATION

FOCUS POPULATION: PATIENTS WITH UNIDENTIFIED BEHAVIORAL HEALTH NEEDS

Program Description and Objective:

Description: The behavioral health integration standards will incorporate standardized, best-practice processes to identify unidentified behavioral health needs in the primary care setting. This program seeks to bolster the ability of providers to perform these functions while optimizing existing resources.

Coordinating care for those with identified chronic behavioral health needs is critical and expected of networks. CCIP standards focus on unidentified behavioral health needs and primary care coordinated interventions in order to avoid duplication with existing programs for higher risk individuals (e.g., the Department of Mental Health and Addiction Service's Behavioral Health Homes).

Objective: To improve the ability of healthcare providers to identify and treat behavioral health needs and to improve the overall state of behavioral health in Connecticut.

High-Level Intervention Design:

1. Identify individuals with behavioral health needs
2. Address behavioral health needs
3. Behavioral health communication with primary care source of referral
4. Track behavioral health outcomes/improvement for identified individuals

1. Identify individuals with behavioral health needs²¹

- 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
- b. The network develops a screening tool that can be self-administered or administered by an individual who does not have a mental health degree²² that includes:
 - i. The PHQ-9 to screen for depression
 - ii. Standardized and validated screening tools for behavioral health needs outside of depression

²¹ The screening is not intended to identify individuals with severe and persistent mental illness

²² The tool does not have to screen for a diagnosis but screen for areas of concern for follow-up by a licensed behavioral health specialist, and the individual who administers the tool should be trained to flag when follow-up screening of additional needs is required by a licensed clinician. Patients aged 12 and older, when possible, should complete the screening tool without the support of their parents.

- c. The network ensures there are support services to administer the tool for individuals with barriers to filling out the screening tool on their own²³
- d. The network utilizes a trained behavioral health specialist on site or through referral (at least with masters level training) who is expected to do a more targeted follow-up assessment²⁴ with the individual when necessary
- e. The network conducts the behavioral health screening no less often than every two years
- f. The network develops a process for identifying a re-screening at each routine visit²⁵
- g. The screening tool results are captured in the EMR and made accessible to all relevant care team members

2. Address behavioral health needs

- a. The network conducts an assessment of needed behavioral health resources to support its practices and establishes the necessary relationships with behavioral health providers to meet those needs
- b. If sufficient behavioral health services are not in network, the network executes an MOU with at least one behavioral health clinic and/or practice and develops processes and protocols for other behavioral health providers that include²⁶
- c. The network use standardized set of criteria to determine whether or not the behavioral health need can be addressed in the primary care setting by a primary care provider that considers²⁷:
 - i. The diagnosis/behavioral health need
 - ii. Severity of the need
 - iii. Comfort level of the primary care team to manage the individual's needs
 - iv. Complexity of the required medication management
 - v. Age of the individual
 - vi. Individual preference
 - vii. If the provider doing medication management for the individual has psychiatric medication management training

²³ The networks should encourage patients aged 12 or older, when possible, to complete the screening tool without the support of their parents.

²⁴ The assessment should reflect the needs identified by the screening tool.

²⁵ This re-screening could include questions asked about changes by doctor or nurse as part of routine visit.

²⁶ This is recommended to ensure that an individual who chooses to seek care from a provider outside of the network or with whom there is no MOU is still assisted and supported in the referral process and does not feel pressured to receive care from a limited set of providers. Additionally, behavioral health needs vary and it may not be realistic to have providers in the network or MOUs with the extent of providers that cover the breadth of behavioral health needs that may arise (e.g., addiction treatment, depression, anxiety, etc.). Processes and protocols should identify how information will be exchanged with provider for whom there is not an MOU (e.g., release of information)

²⁷ If the individual can be treated in the primary care setting, it is expected that the individual be engaged to determine where they would prefer to receive care including primary care provider in the primary care setting, a behavioral health specialist in a behavioral health setting, or behavioral health specialist in a primary care setting if possible. If the individual's needs cannot be addressed in the primary care setting, it is expected the individual be engaged to inform and educate them on the diagnosis/behavioral health need and why a referral/care from a behavioral health specialist is recommended. The individual who engages the individual should be the behavioral health trained care provider with whom the individual is most comfortable.

- d. The network has a mechanism for identifying available behavioral health resources and educates the individual on what these resources are regardless of whether or not a referral is needed.²⁸
- e. The network ensures that primary care team members that provide behavioral healthcare will have behavioral health training that covers:
 - i. Behavioral health promotion, detection, diagnosis, and referral for treatment²⁹.
 - ii. Guidelines on how information will be exchanged and within what timeframe
 - iii. Designating an individual to be responsible for tracking and confirming referrals³⁰
 - iv. Developing technology, if possible, to alert the primary care practice when a referral is completed
 - v. Defining a timeframe within which a referral should be completed³¹
 - vi. Appropriate coding and billing³²

3. Behavioral health communication with primary care source of referral

The network develops process, protocol, and technology solutions identified for behavioral health provider to make the assessment and care plan available to the primary care team with appropriate consent

- i. The behavioral healthcare plan outlines treatment goals, including when follow up is required and who is responsible for follow up
- ii. The behavioral health provider is available for consultation as needed by the primary care physician (process for this should be outlined by MOU) if individual is transferred back to the primary care setting

4. Track behavioral health outcomes/improvement for identified individuals

- a. The network utilizes individual tracking tool to assess and document individual progress at one year and other intervals as determined by the provider
- b. The network develops processes and protocols for updating this tracking tool that includes³³:
 - i. Who is responsible for updating
 - ii. Defining intervals at which assessments are made
 - iii. Adjusting treatment when not effective

²⁸ These resources may include but are not limited to: community resources (e.g., support groups, wellness centers, etc.); alternative therapies (e.g., acupuncture); and health promotion services (e.g., women’s consortium).

²⁹ The technical assistance vendor will assist the networks to find appropriate trainings that focus on health promotion, detection, diagnosis and referral for treatment. Trainings identified by the vendor should be made available to all networks via the internet.

³⁰ Consider a designated behavioral health referral coordinator

³¹ Completed means the consultation occurred and information on the consultation was shared with the primary care practice

³² Pending policy developments around same day billing for behavioral health services may alleviate the need for this to be required of the MOU

³³ Consider technological solutions for tracking outcomes such as a disease registry

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 assessment³⁴ 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 available³⁵
 - 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

³⁴ See Appendix F for a link to sample risk assessments

³⁵ 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 examination³⁶ 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 exam³⁷ 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 individual³⁸
- 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 setting³⁹

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 care⁴⁰
 - 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 coordinator⁴¹, that includes:
 - i. Providing products that support oral hygiene if available (e.g., toothbrush, floss, etc.)⁴²
 - ii. Using the built in EMR tools that provide standardized education to the individual based on diagnosis

³⁶ See Appendix F for sample Oral Exam

³⁷ 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

³⁸ 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)

³⁹ 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

⁴⁰ 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

⁴¹ If a health educator or care coordinator is not available other members of the care team can be trained to provide education

⁴² 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 care⁴³
 - 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 providers⁴⁴
 - 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 items⁴⁵:
 - 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

⁴³ Medicaid patient and locations of safety-net facilities, contact CTDHP at 1-855-CT-DENTAL or <https://www.ctdph.com>.

⁴⁴ Networks should consider technologies such as direct messaging or secure messaging

⁴⁵ 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-consults⁴⁶
- 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-consults⁴⁷.

⁴⁶ 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)

⁴⁷ 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-consults⁴⁸
- 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 service⁴⁹
- 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

⁴⁸ 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

⁴⁹ 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.⁵⁰ 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 intervention⁵¹;
 - b. The network develops a process for the responsible professional and/or care team to assess patient medication management needs⁵²

⁵⁰ 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

⁵¹ 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

⁵² 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.⁵³
 - i. Regardless of the model, the pharmacist should have direct care experience and pharmacist credentials are reviewed^{54 55}
 - 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 person⁵⁶.
- 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 caregivers⁵⁷
 - 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:

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

⁵³ 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

⁵⁴ 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.

⁵⁵ 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.

⁵⁶ 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.

⁵⁷ 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 needed⁵⁸.
 - 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 assessment⁵⁹.
 - 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 plan⁶⁰

 - 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.

⁵⁸ 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.

⁵⁹ If the patient has a comprehensive care team or is working with a Community Health Worker, those individuals should also have access.

⁶⁰ 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.