Practice and Transformation Taskforce: CCIP

Design Group 1: Clinical Integration

May 26th, 2015

Meeting Agenda

Item	Allotted Time
1. Meeting Objectives	5 min
2. Key Success Factors for CCIP Participants	20 min
3. CT SIM Goals and CCIP	30 min
4. Prioritization of Clinical Capabilities	30 min
5. Next Steps	5 min

1. Meeting Objectives

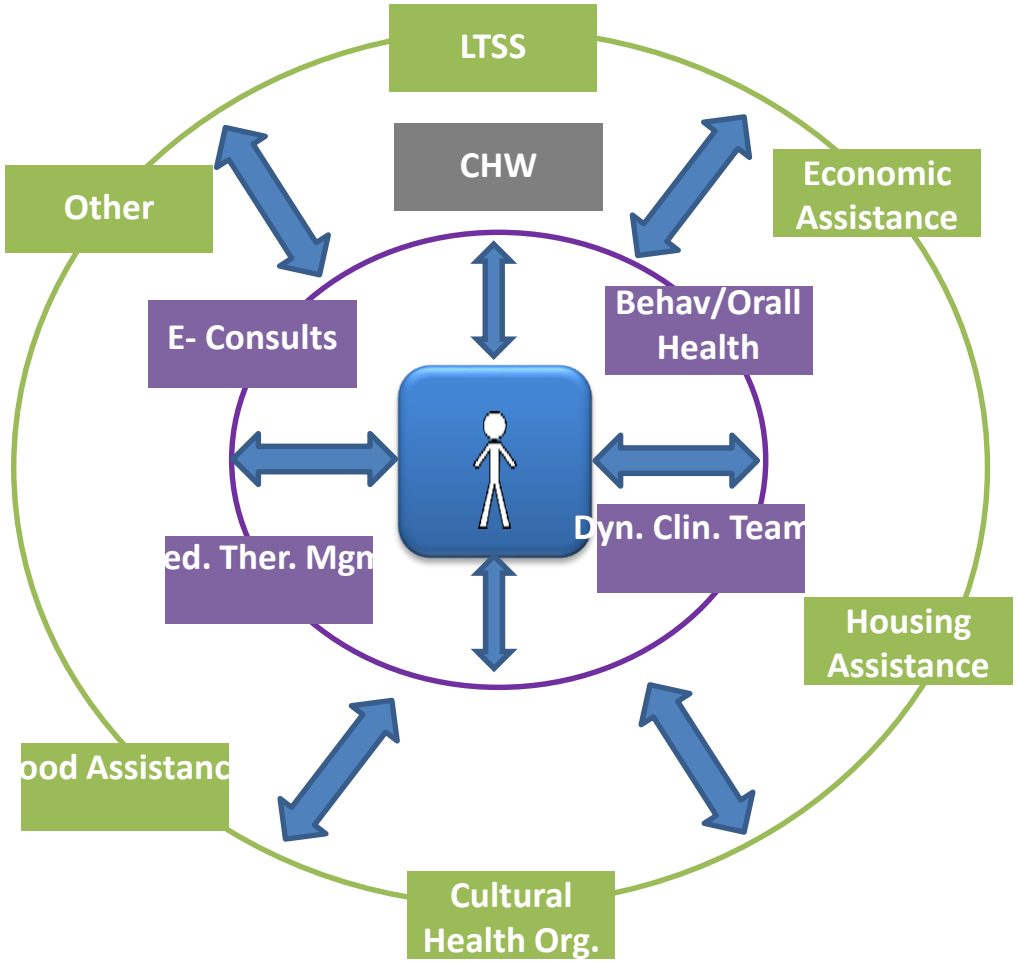
1. Agree on key success factors for CCIP participants

2. Define CT SIM goals and gain understanding of how CCIP will help achieve them

3. Prioritize CCIP capabilities using agreed upon criteria

2. Key Success Factors For CCIP Participants

The key success factor for community and clinical integration is the flexible organization of services, centered around the patient. Additionally, the role of the CHW in the coordination of those services.



- **Identification of complex patients in need of support**
- **Monitoring and improvement of equity gaps, care experience and quality**

- ***How*** these services are organized is determined by the target population and flexible to the needs of that population
- Successful ***implementation*** of capabilities will require accountability between clinical and community partners (i.e.; formal community linkages) and measuring and reporting capabilities that will:
  1. Help inform needs of the population and identify health equity gaps to inform the appropriate target populations and strategies to address their needs
  2. Monitor and evaluate progress toward CT SIM goals and adjust practices to better evolving needs

2. Key Success Factors For CCIP Participants

Another success factor is the continual measurement and reporting of the strength of community linkages to evolve practices and achieve CCIP goals. For example:

What do other SIM states require in their equivalent programs?

health reform MINNESOTA

- A target population supported by community-based data defining the population and its health needs
- Strategies and resources to advance health equity and reach underserved communities
- Community engagement with a variety of community partners

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- Stakeholder commitment to collective impact model
- Experience with collaborative community projects
- Innovations in community-data sharing
- "Backbone organization" that provides data/monitoring services

- Do you agree that measuring and reporting on the strength of community linkages are foundational for community and clinical integration?
- If so, do you agree that an Advanced Network that would like technical assistance only for a clinical capability should have to demonstrate how they are meeting the requirements of measuring and reporting on community linkages?

2. Key Success Factors For CCIP Participants

The remaining CT CCIP capabilities (i.e.; the clinical capabilities) implemented by an Advanced Network will be dependent on the needs of the population.

Advanced Networks will likely identify different target populations, so for the PTTF to pro-actively define a target population and design a model around that would pose a challenge.

<u>Proposed Solution</u>

The Advanced Network conducts a needs assessment to define their target population and designs their own approach to addressing the needs of this population drawing on the capabilities that the PTTF has defined and for which it has created standards

3. Overview of CT SIM Goals and CCIP

The CT SIM grant identifies a number of goals that will be achieved through the various strategic initiatives outlined in the grant.

Goals

- **Population Health**
- **Consumer Engagement**
- **Health inequities** (↓)
- **Cost** (↓)
- **Access** (↑)
- **Quality** (↑)
- **Care Experience** (↑)

Strategic Initiatives
Population Health Management
MQISSP
AMH Glide Path
CCIP
Quality Alignment
Value Based Insurance Design
Consumer Engagement

Each strategic initiative will play a role in moving Connecticut toward achievement of the overall CT SIM Goals

3. Overview of CT SIM Goals and CCIP

Identification of metrics to measure progress on goal achievement are a work in progress, but have been defined in most areas.

Goals	Related Metrics
Population Health	• Plan being completed in short-term • Quality dashboard measures in mid-term
Health Equity	• Health Equity Design Group Measures • Recommendation is to stratify quality measures by race, ethnicity, language and disability data to identify inequities
Access	• Advanced Medical Home metrics • Includes: care experience measures (e.g.; ease of getting an appt.), various means of access (e.g.; after hours, phone and patient portal access)
Quality	• Emerging quality scorecard • Provisional Measures: preventive, acute & chronic conditions, behavioral health, obstetrics • Measures Under Review: care experience, care coordination, patient safety, readmissions, ambulatory sensitive condition admissions, ED measures
Cost	• Overall PMPM
Care Experience	• PCMH Consumer Assessment of Healthcare Providers and Systems (CAHPS) endorsed by the NQF
Consumer Engagement	• Formal plan and metrics yet to be developed

3. Overview of CT SIM Goals and CCIP

Of these goals, the CCIP capabilities will have the most impact on health inequities, access, quality, cost and patient experience.

Goals CCIP Will Contribute to Achieving	
Health Equity *through targeted care interventions*	
Access *through better coordination between providers*	
Quality *through improved care management*	
Cost *through the reduction of potentially avoidable care and better managed care*	
Patient Experience *through providing a person-centered experience*	

3. Overview of CT SIM Goals and CCIP

In addition to the metrics suggested on the previous page, there are a number of enrollment metrics that will be tracked to demonstrate achievement of goals.

CCIP Enrollment Metrics

Year		Advanced Networks		FQHCs		PCPs*	
		Target	Percentage	Target	Percentage	Target	Percentage
2015	Population N	16		14		2,072	
	1st Quarter	0	0%	0	0%	0	0%
	2nd Quarter	0	0%	0	0%	0	0%
	3rd Quarter	0	0%	0	0%	0	0%
	4th Quarter	3	19%	9	64%	516	25%
2016	Population N	16		14		2,072	
	1st Quarter	3	19%	9	64%	516	25%
	2nd Quarter	3	19%	9	64%	516	25%
	3rd Quarter	3	19%	9	64%	516	25%
	4th Quarter	3	19%	9	64%	516	25%
2017	Population N	16		14		2,072	
	1st Quarter	3	19%	9	64%	516	25%
	2nd Quarter	3	19%	9	64%	516	25%
	3rd Quarter	12	75%	14	100%	1,624	78%
	4th Quarter	12	75%	14	100%	1,624	78%
2018	Population N	16		14		2,072	
	1st Quarter	12	75%	14	100%	1,624	78%
	2nd Quarter	12	75%	14	100%	1,624	78%
	3rd Quarter	12	75%	14	100%	1,624	78%
	4th Quarter	12	75%	14	100%	1,624	78%

Notes: PCP counts include those PCPs employed by or affiliated with Advanced Networks and FQHCs; Targets are cumulative totals

Similar metrics exist for other initiatives – AMH, MQISSP, and VBID

Notes: Metrics have not been updated to reflect MQISSP timeline

4. Prioritization of CCIP Capabilities

We will prioritize the CCIP capabilities in a three-step process.

1. Evaluate how each capability could contribute to achievement of the SIM goals, based on demonstrated results from industry experience

2. Assess where CCIP capabilities are complementary to existing programs and where they are redundant to existing programs (within SIM and CT more broadly)

3. Determine if there are synergies between capabilities that when implemented together will have an enhanced impact

4. Prioritization of CCIP Capabilities

The matrix below will be used to help us prioritize the capabilities.

Capability	Impacted?					Indicate Y/N	
	1. Health Equity	2. Access	3. Quality	4. Cost	5. Patient Experience	6. Existing Programs (Y/N)	7. Synergies (Y/N)
Behavioral Health							
Oral Health							
Multi-Disciplinary Team							
Medication Therapy Management							
E-Consults							
Community Health Workers							
Care Transitions							

4. Prioritization of CCIP Capabilities

***Behavioral health* conditions significantly increase costs of care for patients and inpatient admissions, in particular patients with multiple chronic conditions. Better management of behavioral health can improve care and reduce costs.**

Prevalent Model Characteristics?	• Standard procedure to identify patients with behavioral health care needs and standard protocol for follow-up • Various models intended to improve collaboration and communication between behavioral health and primary care. Most include creation of a care team. Three basic models exist: • Coordinated, Co-located, Integrated
Target Population?	• Ranges from patients with minor to severe mental illness • Screening is routine and appropriate protocols are created and followed when concern is identified
Goals/ Outcomes?	• Better management of behavioral health has led to reductions in overall medical care (e.g.; fewer ED visits, IP psychiatric admissions, etc.) • Better management has also been accompanied by lowered costs
Funding?	• Bill for care coordination and behavioral health where possible • Large health system offering services is funding – beneficial because often reduces their overall costs

Health Equity	Access	Quality	Cost	Patient Experience
	✓	✓	✓	

4. Prioritization of CCIP Capabilities

Growing evidence suggests that there is a oral/systemic link. Better control of chronic conditions (e.g.; diabetes) has a positive impact on oral health and vice versa.

Prevalent Model Characteristics?

- Similar integration models are used for oral health as for behavioral health:
  - Coordinated, Co-located, Integrated
- Most focus is on improved education of primary care physician to educate about the importance of good oral health and to assess risk during primary care visit.

Target Population?

- All populations not currently receiving dental healthcare.
- In particular patients with chronic conditions that could be impacted by poor dental health.

Goals/ Outcomes?

- Better treatment of periodontal disease can lead to reduced costs of other chronic conditions

Funding?

- Medicaid CHIP covers dental services
- ACA Medicaid expansion allowed for more Medicaid adult coverage
- Medicare does not cover dental services
- Cigna and Aetna have made efforts to increase/improve dental coverage

Health Equity	Access	Quality	Cost	Patient Experience
	✓	✓	✓	

4. Prioritization of CCIP Capabilities

Multi-disciplinary care teams support better coordination of care and care management. Teams are often dynamically structured to be tailored to the patient's needs.

Prevalent Model Characteristics?

- At a minimum includes a PCP/NP, care coordinator (usually an RN), social workers and community health workers
- Additional providers are made available if needed by patient: more extensive social services, pharmacist, behavioral health specific support, elder care, etc.
- Emphasis put on tailoring to patient with clear definition of role sand responsibilities for all team members

Target Population?

- Multi-disciplinary team is most helpful for populations with complex care needs – clinical and/or social.

Goals/ Outcomes?

- Hennepin model has shown increased PCP visits and reduced ED and IP admissions; Improved quality of care, in particular for diabetes, vascular and asthma care; Improved patient satisfaction

Funding?

- Hennepin model has PMPM payments managed by local health plan – allows for flexibility in reimbursement.
- Medicare will start reimbursing for care coordination

Health Equity	Access	Quality	Cost	Patient Experience
		✓	✓	✓

4. Prioritization of CCIP Capabilities

"Community Health Workers are frontline public health workers who are trusted members of…the community served. This…relationship enables the CHW to serve as a liaison…between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery[1]"

Prevalent Model Characteristics?

- Successful programs do the following:
  - Pay a salary
  - Pair patients with CHW based on race/ethnicity
  - Provide formalized CHW training
  - Meetings at patient's home

Target Population?

- Disease specific target
- Community defined to target specific race/ethnicity
- High resource utilizers

Goals/ Outcomes?

- Improved quality (better health outcomes)
- Improved health equity
- Reduced costs (reduced unnecessary utilization)

Funding?

- Predominately funded through state or federal grants
- State agencies
- ACOs

Health Equity	Access	Quality	Cost	Patient Experience
✓		✓	✓	

Notes:[1] Community Health Workers: A Review of Program Evolution, Evidence on Effectiveness and Value, and Status of Workforce Development in New England; Comparative Effectiveness Public Advisory Council; 2013

4. Prioritization of CCIP Capabilities

***Care Transitions** refers to the movement of a patient from one healthcare setting to another as the patient's care needs change, in particular the transition from a hospital to another care setting or home.*

Prevalent Model Characteristics?

- Patient education on red flags
- Development of personal health record for us by patient – includes medication reconciliation
- Engaged primary care provider
- Interdisciplinary team supports transition (RNs, SWs, and physicians) – could include care transition coach
- Accurate and timely sharing of information to relevant providers (e.g.; discharge checklist)

Target Population?

- Hospitalized patients with complex care needs at high-risk for readmission

Goals/ Outcomes?

- Reduced readmissions
- Improved patient experience

Funding?

- Grants
- Hospital funded

Health Equity	Access	Quality	Cost	Patient Experience
		✓	✓	✓

4. Prioritization of CCIP Capabilities

E-consults refers to electronic referral and consultation systems intended to improve the primary care physician-specialist referral process and address specialist shortages

Prevalent Model Characteristics?

- Specialty referral request sent by primary care physicians via an electronic means of communication connected to a patient's electronic health record
- Requests sent to a physician specialist, some programs use a designated specialist to screen the referral for completeness and appropriateness
- E-consults can complement or replace the traditional referral process
- Physician communication can be synchronous or asynchronous

Target Population?

- Medicaid and other healthcare safety net populations with limited access to specialty care

Goals/ Outcomes?

- Timely access to specialty care, reduced patient wait times for specialist appointments
- Reduced cost from potentially avoidable specialist referrals and associated IP and OP utilization

Funding?

- Health system and grant funded
- Select state Medicaid programs

Health Equity	Access	Quality	Cost	Patient Experience
	✓	✓	✓	

4. Prioritization of CCIP Capabilities

Integration of pharmacist-provided medication therapy management (MTM) as part of an interdisciplinary primary care team

Prevalent Model Characteristics?

- MTM services typically include a comprehensive review of current meds; assessment of appropriateness, efficacy, safety and adherence to support therapeutic goals; and documentation and communication of care plan to patient and health care providers
- The spectrum of MTM models include basic coordination, co-location, and full integration
- Patient interaction can take a variety of forms including F2F visits, phone and electronic communication, and take place at home, pharmacies, physician offices, hospitals etc.

Target Population?

- Patients with multiple chronic conditions, complex medication regimens, propensity for high use, failure to achieve treatment goals, and multiple care transitions

Goals/ Outcomes?

- Improved outcomes for treatment goals (e.g., diabetes and other chronic conditions)
- Reduced medication and other health care utilization cost/claim and annual cost/patient
- Improved patient satisfaction

Funding?

- Grant funded pilot or demonstration projects, providers with P4P quality programs
- Medicare Part D for narrow set of MTM services that are generally provided by payers

Health Equity	Access	Quality	Cost	Patient Experience
		✓	✓	✓

4. Prioritization of CCIP Capabilities

All capabilities demonstrate an impact on quality and cost with a noted impact in other areas of interest for some capabilities.

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	1. Health Equity	2. Access	3. Quality	4. Cost	5. Patient Experience	6. Existing Programs (Y/N)	7. Synergies (Y/N)
Behavioral Health		✓	✓	✓			
Oral Health		✓	✓	✓			
Multi-Disciplinary Team			✓	✓	✓		
Medication Therapy Management			✓	✓	✓		
E-Consults		✓	✓	✓			
Community Health Workers	✓		✓	✓			
Care Transitions			✓	✓	✓		

4. Prioritization of CCIP Capabilities

There are other programs in Connecticut today that should be considered when establishing the clinical capabilities.

Dual Eligible Health Neighborhoods:
Employs care coordination model that is similar to multi-disciplinary team. Program has identified relevant process and outcome metrics.

DHMAS Behavioral Health Homes:
Also employs care coordination model that is similar to multi-disciplinary team. Program has identified relevant process and outcome metrics. Literature suggests that health home serve as a good starting point for behavioral health integration.

Money Follows Person:
Program has experience with developing community linkages, home based care, care transitions, and workforce development.

E-Consults:
Partnership with UCONN to research effectiveness of e-consults for cardiology and other specialty services has been informative.

Behavioral Health Design Group:
Developed set of recommendations that could serve as starting point for CCIP work.

Note: DSS will do a presentation on all the relevant programs that could be related to the CCIP capabilities so design can be informed by already existing activities.

4. Prioritization of CCIP Capabilities

All capabilities demonstrate an impact on quality and cost with a noted impact in other areas of interest for some capabilities.

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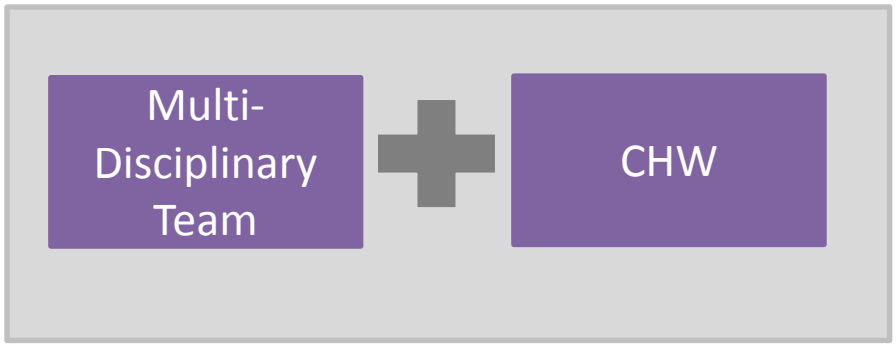
Oral Health		✓	✓	✓			
Multi-Disciplinary Team			✓	✓	✓	✓	
Medication Therapy Management			✓	✓	✓		
E-Consults		✓	✓	✓		✓	
Community Health Workers	✓		✓	✓			
Care Transitions			✓	✓	✓	✓	

4. Prioritization of CCIP Capabilities

While all of the CCIP capabilities could be implemented on their own, it is worthwhile to consider potential synergies between capabilities that when implemented together there would be a greater impact.



- Most of the CCIP like models reviewed last week include a CHW as part of the multi-disciplinary team.
- We propose the role of the CHW in linking the patient to community support would be stronger if the CHW is a member of the care team.
- ***Should these two capabilities be implemented together to enhance impact?***

Are there other capabilities that will have synergies?

- Medication Therapy Management as part of Multi-disciplinary team?
- Other?

4. Prioritization of CCIP Capabilities

All capabilities demonstrate an impact on quality and cost with a noted impact in other areas of interest for some capabilities.

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Behavioral Health		✓	✓	✓		✓	
Oral Health		✓	✓	✓			
Multi-Disciplinary Team			✓	✓	✓	✓	✓
Medication Therapy Management			✓	✓	✓		✓
E-Consults		✓	✓	✓		✓	
Community Health Workers	✓		✓	✓			✓
Care Transitions			✓	✓	✓	✓	

5. Next Steps

- Chartis will work with experts from PTTF and outside sources if necessary between this design group session and the next to develop a set of straw man descriptions and standards for each clinical capability
- As the straw man descriptions and standards are developed they will be shared with the group offline to elicit feedback and then revised.
- Updated descriptions and standards will be reviewed at the second design group session.