Practice Transformation Task Force:

CCIP Development, Design Group 1, Session 2

July 16th, 2015

Meeting Agenda

Item	Allotted Time
1. Meeting Objectives	5 min
2. Program Design Overview: Complex Patients and Patients with Equity Gaps	50 min
3. Case Studies From Similar Programs Ranging in Design Specificity	25 min
4. Summary of Key Themes & Questions for Broader PTTF	5 min
5. Next Steps	5 min

1. Meeting Objectives

1. Gain agreement on high level program designs for:
   a) Complex Patients
   b) Patients Experiencing Equity Gaps

2. Obtain group's perspective on desired level of specificity of PTTF recommendations on design and standards

3. Identify key themes and questions to discuss with broader PTTF

2. Program Design Overview

Today we are going to focus on the more detailed design of the CCIP programs for complex patients and patients experiencing equity gaps.

Core

Complex Patients (clinically and socially)

Multi-Disciplinary Team ✚ CHW

Community and Clinical Linkages

Quality Scorecard

- Reduce readmissions
- Reduce ambulatory sensitive condition admissions

Populations Experiencing Equity Gaps

CHW ✚ Community and Clinical Linkages

- Health Equity Design Group metrics

Behavioral Health

Behavioral Health Integration (screening, integrated BH care or referral to BH provider, confirm linkage to provider, follow-up)

- PCMH CAHPS BH access measures
- BH screening/ depression remission

Elective

Care Experience *Medication Therapy Management* *E-Consult* *Oral Health*

2. Program Design Overview

Now that there is agreement on the core elements of each program, we suggest that the group provide names for the programs that represent what the program's will do to address the needs of the target populations.

Suggestions:

Complex Patients (clinically and socially)

Comprehensive Community Care Team (CCCT) Program

Populations Experiencing Equity Gaps

Health Equity Improvement (HEI) Program

Does the group have other suggestions for names?

2. Program Design Overview

As a reminder the PTTF's overall goal is to develop a program objective, standards, and implementation guidelines for the three core programs identified and the elective clinical capabilities. The following process will be followed in in order to get to the final objective.

As we walk through the materials today, please consider the questions in italics under each step

Step 1:
Develop program definition and objective

- *Is this comprehensive?*
- *Is this representative of what the group wants the program to accomplish?*

Step 2:
High level program design

- *Will this achieve the desired objective?*
- *Is this the right process? Are there elements missing? Elements that should be removed?*

Step 3:
Standards for program design

- *Are additional standards needed?*
- *Are any standards not needed?*

Step 4:
Implementation guidelines for standards

- *Is this the desired level of specificity?*
- *How will more/less specificity impact making the approach whole-person centered?*
- *Consider feasibility of implementation:*
  - *Technological implications*
  - *Network structure and infrastructure*

2. Program Design Overview: Step 1

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2. Program Design Step 1: CCCT Objective & Definition

The objective and definition of the comprehensive community care team program is as follows:

Objective: The Comprehensive Community Care Team is intended to address the needs of complex patient populations. Complex patient populations have been defined by the PTTF as patients who have either multiple complex medical conditions, multiple complicated social needs, or a combination of both that often lead to preventable service utilization and poorer overall healthcare management, ultimately impacting health outcomes.

Definition: Current research suggests that crucial to addressing the needs of complex patients, as they have been defined by the PTTF, is comprehensive care management that integrates care delivery across the clinical and community setting to address the clinical and social needs of the patient. In practice this is typically done through the use of a multidisciplinary care team that is inclusive of a Community Health Worker (CHW) and through forging formal linkages between the Advanced Network/FQHC and community organizations that provide crucial social support to the targeted population. The multidisciplinary care team is comprised of clinical and non-clinical practice team members who are charged with supporting better care coordination, health promotion, and providing comprehensive care management across the clinical and non-clinical settings. In particular the social needs, often referred to as social determinants of health, which tend to negatively impact overall health outcomes. The more focused care management of the multidisciplinary care team is intended to:

- Support the individual to address psychosocial barriers to care through identifying and connecting the patient to needed social and behavioral support
- In the short-term, work with the patient to establish clinical and non-clinical care goals and support them in meeting those goals
- Through the more intensive process of working with the multidisciplinary team, improve overall patient engagement to support longer-term self-care management

2. Program Design Overview: Step 2

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2. Program Design Step 2: CCCT High Level Design

1. Identify Complex Patient Eligible for CCCT Program
2. Connect Patient to Comprehensive Community Care Team
3. Comprehensive Community Care Team Assesses Patient Needs (Clinical – Social – Behavioral)
4. Comprehensive Community Care Team and Patient/Family Develop a Shared Care Plan Based on Needs Assessment
5. Comprehensive Community Care Team Execute and Monitor Care Plan
6. Patient Ready to Discontinue from CCCT Program

2. Program Design Overview: Step 3 & 4

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2. Program Design Step 3: CCCT Standards

1 **Identify Complex Patients Eligible for CCCT Program**

How will Advanced Networks/FQHCs determine which patients are eligible to be a part of the CCCT program?

The AN/FQHC will have to define what complex means more specifically – what clinical, social and behavior characteristics make a patient complex?

Standard:

A. Develop inclusion/exclusion criteria to apply to the network attributed patient population to determine which patients are "complex" and eligible for intervention

2. Program Design Step 4: CCCT Implementation

A. Develop inclusion/exclusion criteria to apply to the network attributed patient population to determine which patients are "complex" and eligible for intervention

- Consider the following criteria for inclusion/exclusion:
  - High IP and/or ED utilization (e.g.; greater than two IP admissions over the past 6 months) taking into consideration what the admission was for (i.e.; scheduled procedure, oncology or pregnancy, acute condition, etc.)
  - Presence of multiple chronic conditions
  - Complex medication regimens (e.g. greater than 5 medications)
  - Difficulty accessing services (e.g.; language barrier, low health literacy, "non-compliant", etc.)
  - Level of social support at home or in the community
  - Known mental health conditions or substance abuse
  - Homelessness
  - Insurance status

2. Program Design Step 3: CCCT Standards

2 **Connect Patient to Comprehensive Community Care Team**

Who will make up the comprehensive community care team?

How will the comprehensive community care team be built and deployed?

How will AN/FQHC use available clinical data to identify which attributed patients meet the CCCT inclusion criteria? – Addressed by Design Group 3 (standard D)

In practice, how/where will the AN/FQHC enroll patients into the CCCT once they are identified as eligible?

Standards:

B. **Identify members of comprehensive community care team, develop necessary training protocols, and define roles**

C. **Develop comprehensive community care team (inclusive of a Community Health Worker) to support a minimum of 5 practices in Advanced Networks/FQHCs**

D. **Establish analytic method and apply it to attributed patients within the five or more identified practices to determine which are "complex" and eligible to participate in the Comprehensive Community Care Team intervention**

E. **Draft and implement a process to enroll patients into the Comprehensive Community Care Team intervention based on the list of eligible patients provided by the network**

2. Program Design Step 4: CCCT Implementation

B. Identify members of comprehensive community care team, develop necessary training protocols, and define roles

- At a minimum comprehensive community care teams should include:
  - An RN to manage care coordination
  - A social worker to address education, self-care management, and social needs; and,
  - A community health worker (CHW) to coordinate access to social services and represent the patient's non-clinical needs (social, environmental, etc.) to the rest of the comprehensive community care team
- Define required training for all comprehensive community care team members:
  - RN care coordination training protocol should include_____
  - Social Worker should have training in _____
  - CHWs training protocol should require specifying training in x resulting in y certification
- Develop job descriptions for all comprehensive community team members.
  - The CHW job description should include, at a minimum, the following key responsibilities:
    - Staying up to date on key educational topics relevant to their patient population
    - Maintaining relationships with key community resources
    - Pro-actively reaching out to the patient to assess ongoing needs and promote continuity of care to improve health outcomes
    - Represent the social and behavioral needs of the patient in the clinical setting and surface any barriers the patient is experiencing preventing him/her from achieving improved health status
  - The CHW should have, at a minimum, the following background:
    - Representative in some manner of the patient population they are supporting (e.g.; culturally, geographically, clinical profile, etc.)

2. Program Design Step 4: CCCT Implementation

C. Develop comprehensive community care team to support a minimum of 5 practices in Advanced Networks/FQHCs

- Provide justification for why five practices were chosen
- For justification consider:
  - Analysis to show they are practices with highest need
  - Practice infrastructure to support comprehensive community care team
  - Current practice resources (i.e.; already have comprehensive community care team members)

E. Draft and implement a process to enroll patients into the Comprehensive Community Care Team intervention based on the list of eligible patients provided by the network

- Specify points of service at which patients will be approached to enroll in the CCIP intervention (i.e.; hospital, emergency department, primary care practice, pro-actively reach out)
- Identify individual in network responsible for enrolling patient into CCIP intervention *[Will depend on overall process for enrolling]*
- Confirm patient is eligible for participation based on inclusion/exclusion criteria
- If patient is not enrolled in the primary care setting, set up primary care visit to occur within the next 7 days

Implementation Guidelines for Standard D Will Be Addressed by Design Group 3

2. Program Design Step 3: CCCT Standards

3 **Comprehensive Community Care Team Assesses Patient Needs (Clinical – Social – Behavioral)**

Patient

Comprehensive Community Care Team

How should the patient's needs be assessed?

Once an eligible patient is connected to the CCCT, the team will have to assess the patient's needs in order to develop a patient-centered care plan

Standards:

F. Develop a needs assessment that evaluates the patient's clinical, social, and behavioral needs

G. Draft and implement a process for administering the needs assessment

2. Program Design Step 4: CCCT Implementation

F. Develop a needs assessment that evaluates the patient's clinical, social, and behavioral needs

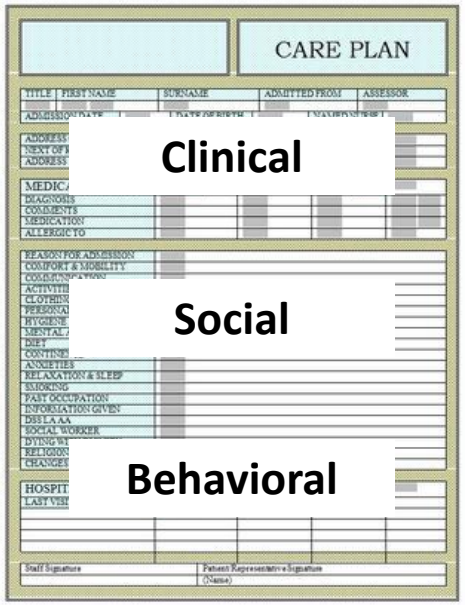
- The needs assessment should assess clinical, behavioral and social needs
- The clinical assessment should include_____
- The behavioral assessment should cover mental health, substance abuse, and trauma
- The social needs assessment should cover family/social/cultural characteristics, communication needs (including language needs), behaviors affecting health, assessment of health literacy, and barriers to care

G. Draft and implement a process for administering the needs assessment

- Identify person(s) responsible for administering needs assessment/sections of assessment
- Initiate administration of needs assessment within a week of enrollment into Comprehensive Community Care Team intervention

2. Program Design Step 3: CCCT Standards

4 Comprehensive Community Care Team and Patient/Family Develop a Shared Care Plan Based on Needs Assessment



Standards:

H. Develop a standardized shared care plan to complete for each patient

I. Draft protocol that identifies which comprehensive community care team member is responsible for each part of the care plan and policies for completing the care plan

2. Program Design Step 4: CCCT Implementation

H. Develop a standardized shared care plan to complete for each patient

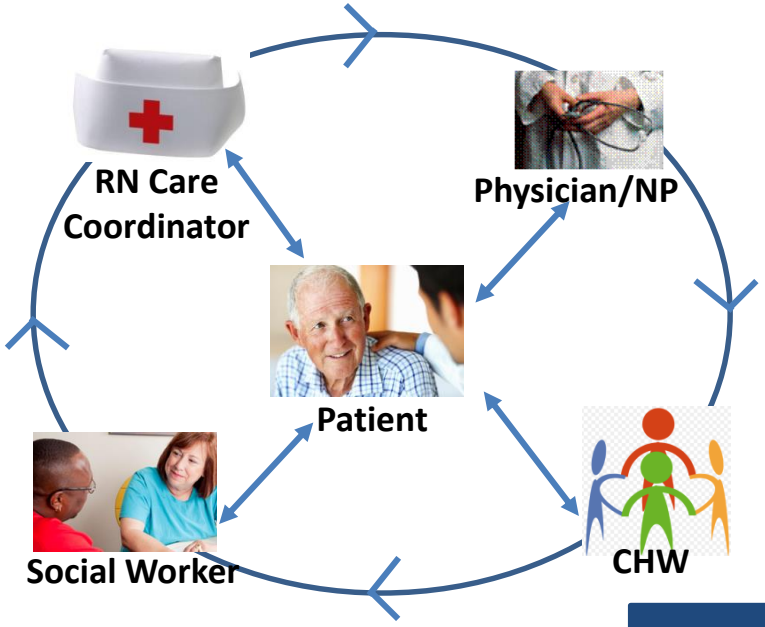
- Care plan should map to needs identified through needs assessment and identify treatment goals
- The care plan should contain:_____

I. Draft protocol that identifies which comprehensive community care team member is responsible for each part of the care plan and policies for completing the care plan

- Identify comprehensive community care team member(s) responsibilities for completing the care plan (i.e.; who is responsible for which sections, who finalizes the plan, etc.)
- Involve the patient and/or family members in the development of the care plan
- Make the completed care plan available and easily accessible to all team members
- Complete the care plan within a week (?) of when the needs assessment was conducted
- Establish process to introduce patient to each comprehensive community care team member

2. Program Design Step 3: CCCT Standards

5 **Comprehensive Community Care Team Execute and Monitor Care Plan**



How will communication about the patient's care between the community care team and patient occur?

The ability of the community care team to communicate with ease in a standardized manner with the patient and with each other will be a key success factor

Standards:

J. Draft and implement policies for comprehensive community care team meetings

K. Draft and implement guidelines for comprehensive community care team interaction with patient

L. Draft and implement process for tracking patient progress on care plan and making that information available to the rest of the comprehensive community care team

2. Program Design Step 4: CCCT Implementation

J. Draft and implement policies for comprehensive community care team meetings

- Establish frequency for comprehensive community care team case reviews to monitor/evaluate client status and service needs (i.e.; review progress on the care plan and to discuss barriers to meeting treatment goals)
- Identify the meeting setting (i.e.; in person, phone, etc.) and a standard agenda that outlines what information should be shared and by whom during the meeting
- Topics covered on the agenda, at a minimum, should include:_____
- Develop method to hold team members accountable for participating in team meetings

K. Draft and implement guidelines for comprehensive community care team interaction with patient

- Establish the minimum number of interactions the comprehensive community care team member should have with the patient
- Define a timeline for which interactions between the comprehensive community care team and the patient will occur
- Define the setting for comprehensive community care team interactions with the patient

2. Program Design Step 4: CCCT Implementation

L. Draft and implement process for tracking patient progress on care plan and making that information available to the rest of the comprehensive community care team

- Define standardized set of information to document on care plan during each patient interaction

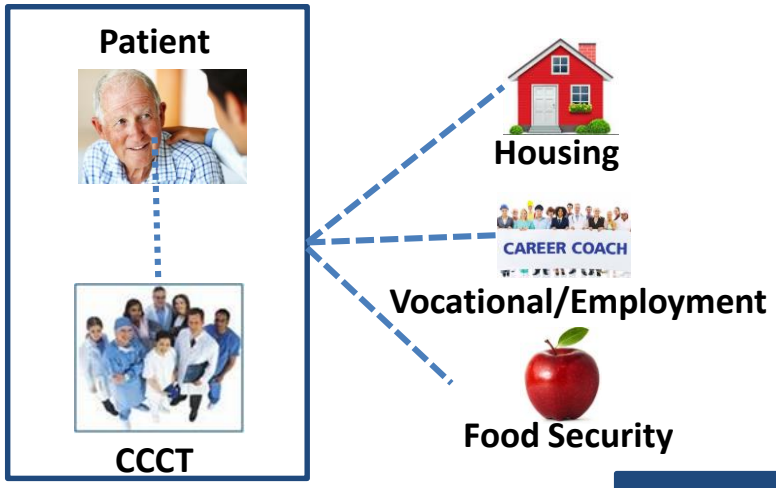
- Establish timeframe within which comprehensive community care team members should update the care plan and create a progress note for the patient after every interaction

- Establish how comprehensive community care team will be responsible for collecting and tracking patient data (i.e.; progress notes, updates to care plan, newly identified challenges/barriers) related to the care plan. This should include establishing where information will be stored and how it will be made accessible to all members of the team

- Develop capabilities for the comprehensive community care team to routinely communicate key information captured through patient interactions with the rest of the care team in between formal team meetings (e.g.; direct messaging)

2. Program Design Step 3: CCCT Standards

5 **Comprehensive Community Care Team Execute and Monitor Care Plan**



The development of community linkages will be addressed by Design Group 2 (standards M-N)

Program evaluation parameters will be addressed by Design Group 3 (standard O)

Standards:

M. Develop and execute relationships with nutritional assistance, housing, and vocational/employment assistance organizations for the comprehensive community care team to draw on to execute the care plan

N. Draft and implement guidelines for connecting patients with other community resources with which the Advanced Network/FQHC does not have formal linkages

O. Develop program evaluation parameters and capabilities to be reviewed and updated on an annual basis

2. Program Design Step 4: CCCT Implementation

Standards M-N Implementation Guidelines Will Be Addressed by Design Group 2

Standard O Implementation Guidelines Will Be Addressed by Design Group 3

2. Program Design Step 3: CCCT Standards

6 **Patient Ready to Discontinue from CCCT Program**

Through CCCT the patient has….

- ✓ Been connected to needed social support services
- ✓ Engaged in his/her health care
- ✓ Developed self-management skills
- ✓ Achieved their goals on the shared care plan

How will the comprehensive community care team know when the patient can "graduate"?

The patient will not continually need the intensive support of the community care team and the AN/FQHC will have to develop a way to know when community care team support is no longer needed

Standard:

P. Develop or identify criteria to identify when patients can be discontinued from the Comprehensive Community Care Team Intervention

2. Program Design Step 4: CCCT Implementation

P. Develop or identify criteria to identify when patients can be discontinued from the Comprehensive Community Care Team Intervention

- Develop or identify evaluation tool that assess patient readiness for care self-management (e.g.; Client Perceptions of Coordination Questionnaire – CPCQ)

Are there other measures the PTTF is aware of that could evaluate a patient's readiness for self-management?

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2. Program Design Step 1: HEI Objective & Definition

The objective and definition of the health equity improvement program is as follows:

Objective: The objective of the Health Equity Improvement (HEI) program is to identify and close equity gaps experienced by patients. Patients experiencing health equity gaps are defined as those belonging to a specific subset of patients who are experiencing a disparity in care demonstrated through a difference in treatment patterns and/or health outcomes. The community focused equity gap intervention will be designed around x,y,z population subsets (TBD) experiencing gaps in clinical outcomes aligned with the CT SIM quality scorecard (provisionally, this may include diabetes, asthma, and hypertension).

Definition: The Practice Transformation Taskforce (PTTF) has developed standards for a community focused program to address identified equity gaps. The community approach recognizes the role social and cultural factors can play in contributing to gaps in care and seeks to address those issues. The PTTF has identified the use of Community Health Workers and the formation of clinical-community linkages to crucial social services as, at a minimum, the key capabilities needed to address equity gaps.

2. Program Design Step 1: HEI Objective & Definition

Definition Contd.: Health equity gaps often arise from language and health literacy barriers, challenges with the cultural competency of providers, and cultural gaps in methods of patient education. This presents a particular challenge amongst patients who have more complex chronic illnesses that often contain lifestyle components as part of the treatment. A wealth of research suggests that Community Health Workers (CHWs) can successfully address the gaps in care patients experience and improve overall outcomes. Similar to the role a CHW plays as a member of a comprehensive community care team, the CHW addressing health equity gaps will:

- Support the individual to address psychosocial barriers to care through identifying and connecting the patient to needed social and behavioral support and act as a representative of those needs within the clinical setting
- In the short-term, work with the patient to establish clinical and non-clinical care goals and support them in meeting those goals
- Through the more intensive process of working with the patient to address equity gaps, improve overall patient engagement to support longer-term self-care management

While the role of CHWs to address equity gaps is similar to the role played on a comprehensive community care team it also differs in several key ways:

- The CHW training will be focused on providing disease specific training, health promotion, education and peer support
- The knowledge base of community resources and established community resource relationships will differ as they will likely need to be more disease state specific and/or geared toward addressing cultural needs
- The CHW does not need to be part of a multidisciplinary team, but should have frequent and formal interactions with or be part of the primary care team

In addition to the CHW the Advanced Network/FQHC should develop formal relationships with 1-2 community organizations that will support addressing the needs of their target population.

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2. Program Design Step 2: HEI High Level Design

1. Identify Patients Experiencing Equity Gaps
2. Connect Patient to Community Health Worker (CHW) Trained to Address Gap
3. CHW Conducts a Needs Assessment
4. CHW Develops a Care Plan Based on Needs Assessment
5. CHW Executes and Monitors Care Plan
6. Patient Ready to Discontinue from CCIP Intervention

2. Program Design Overview: Step 3 & 4

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2. Program Design Step 3: HEI Standards

1 **Identify Patients Experiencing Equity Gaps**

The PTTF is still deliberating on which population subsets for which equity gaps will be evaluated, but likely gaps will be assessed along clinical outcomes that align with the CT SIM quality scorecard (i.e.; diabetes, asthma, and hypertension)

The Definition will…

…inform the analytic method Advanced Networks/FQHCs utilize to identify which attributed patients are experiencing equity gaps and are eligible for the Health Equity Improvement Program

Standard:

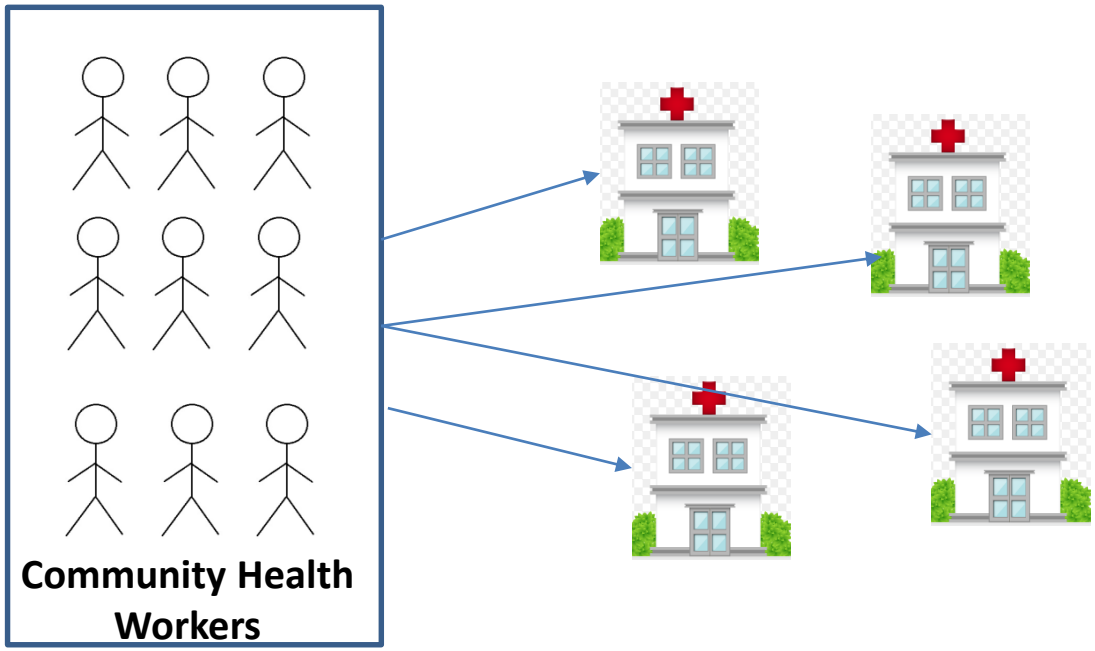
A. Establish analytic method to identify equity gaps (as defined by the PTTF) within the Advanced Network/FQHC attributed population to determine who is eligible for the Health Equity Improvement Program

2. Program Design Step 4: HEI Implementation

Standards A Implementation Guidelines Will Be Addressed by Design Group 3

2. Program Design Step 3: HEI Standards

2 **Connect Patient to Community Health Worker (CHW) Trained to Address Gap**



- How will CHWs be made available to patients experiencing equity gaps?
- What will the CHWs do for patients with equity gaps?
- Will they need special training?

Standards:

B. Draft and implement process to deploy Community Health Workers to practices to work with patients experiencing equity gaps

C. Define role of Community Health Worker and necessary training protocols

2. Program Design Step 4: HEI Implementation

B. Draft and implement process to deploy Community Health Workers to practices to work with patients experiencing equity gaps

- AN/FQHC should establish a relationship/agreement with a Community Health Worker organization with CHWs trained in the specified clinical area identified for intervention
- Determine reasonable caseload per CHW and process to assign CHWs to patients

C. Define role of Community Health Worker and necessary training protocols

- CHWs training protocol should require specific training in the disease state of the equity gap being addressed and result in _____certification
- The CHW job description should include, at a minimum, the following key responsibilities:
  - Staying up to date on key educational topics relevant to their patient population
  - Maintaining relationships with key community resources
  - Pro-actively reaching out to the patient to assess ongoing needs and promote continuity of care to improve health outcomes
  - Represent the social and behavioral needs of the patient in the clinical setting and surface any barriers the patient is experiencing preventing him/her from achieving improved health status
- The CHW should have, at a minimum, the following background:
  - Representative in some manner of the patient population they are supporting (e.g.; culturally, geographically, clinical profile, etc.)

2. Program Design Step 3: HEI Standards

3 **CHW Conducts a Needs Assessment**

Patient

Community Health Worker

How should the patient's needs be assessed?

Once an eligible patient is connected to the CHW, the CHW with the primary care team will have to assess the patient's needs in order to develop a patient-centered care plan

Standards:

D. Develop a needs assessment that evaluates the patient's social and behavioral needs with an emphasis on social and behavioral barriers leading to equity gaps

E. Draft and implement a process for administering the needs assessment

2. Program Design Step 4: HEI Implementation

D. Develop a needs assessment that evaluates the patient's social and behavioral needs with an emphasis on social and behavioral barriers leading to equity gaps

- The needs assessment should focus on behavioral and social (in particular cultural and language needs) needs that are impacting the clinical area in which the AN/FQHC has identified equity gaps

- The behavioral assessment should cover mental health, substance abuse, and trauma that may be impacting the patient's ability to achieve better health outcomes

- The social needs assessment should cover family/social/cultural characteristics, communication needs (including language needs), behaviors affecting health, assessment of health literacy, and barriers to care

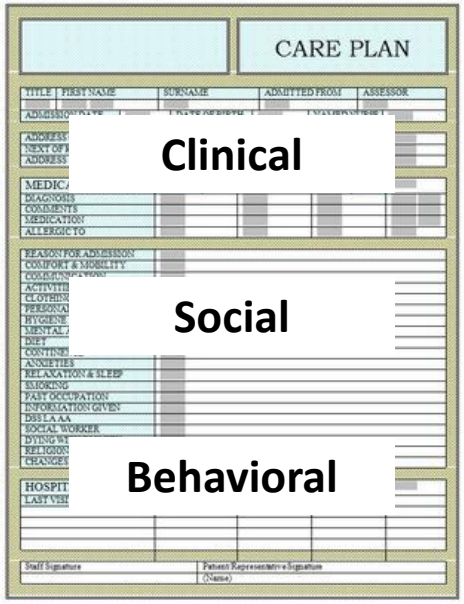
E. Draft and implement a process for administering the needs assessment

- The needs assessment should be conducted in the patient's home

- The assessment should be made available by electronic means to the patient's primary care team

2. Program Design Step 3: HEI Standards

4 **CHW Develops a Care Plan Based on Needs Assessment**



Standard:

F. Develop a standardized care plan for CHW to complete for each patient

The Care Plan for the HEI program will differ from the CCCT program assessment - putting a greater emphasis on addressing social factors more likely to lead to equity gaps (e.g.; language barriers, health literacy, etc.)

2. Program Design Step 4: HEI Implementation

F. Develop a standardized care plan for CHW to complete for each patient

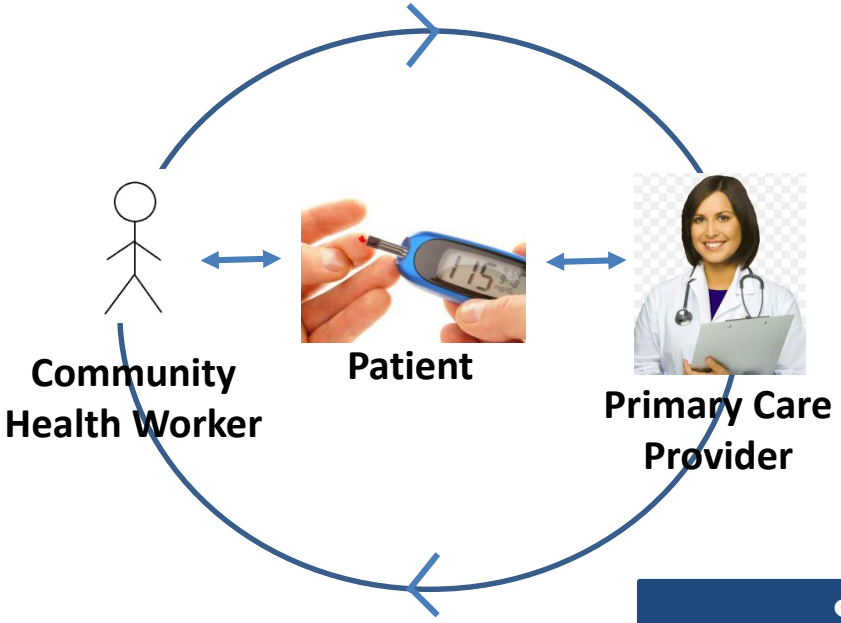
- The care plan should map to the behavioral and social needs/barriers to care identified in the needs assessment

- The care plan should contain:_____

Does the group have thoughts on what elements should be required on the care plan?

2. Program Design Step 3: HEI Standards

5 **CHW Executes and Monitors Care Plan**



How will the community health worker be integrated into the primary care team to promote seamless communication and coordination of care for the patient?

Policies and infrastructure should allow for the CHW to be integrated into the primary care team in a manner that supports seamless communication about progress and/or barriers to success on the care plan

Standards:

G. Draft and implement policies and procedures that define how CHWs will function within the primary care team and otherwise integrate their roles into the primary care work flows

H. Draft and implement guidelines for Community Health Worker interaction with patient

I. Draft and implement process for tracking patient progress on the care plan and making that information available to the primary care team

2. Program Design Step 4: HEI Implementation

G. Draft and implement policies and procedures that define how CHWs will function within the primary care team and otherwise integrate their roles into the primary care work flows

- CHWs will report to _____
- CHWs will participate meetings with primary care team to discuss challenges/barriers patients are experiencing and to identify potential solutions
- Establish how frequently CHW will meet with primary care team
- Topics covered on the agenda should include:_____
- CHWs will be responsible for collecting and tracking _____ data for the primary care practice

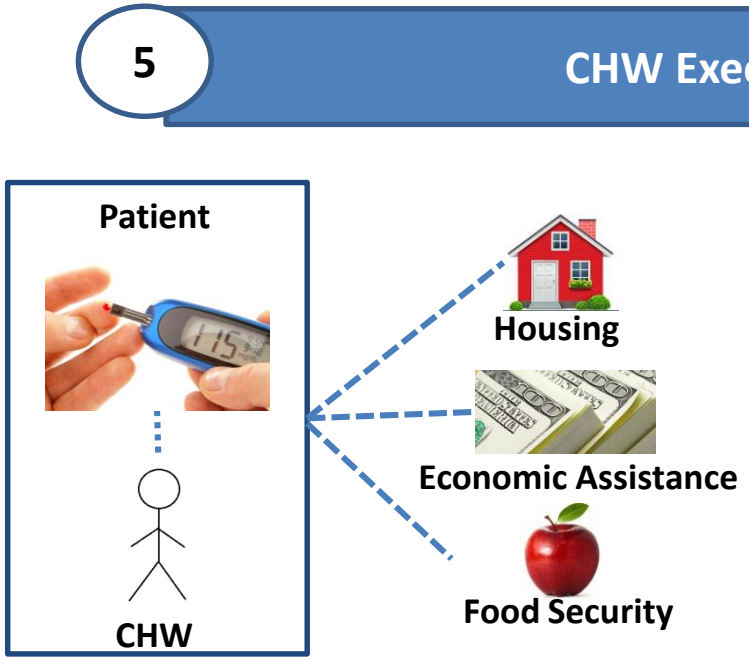
H. Draft and implement guidelines for Community Health Worker interaction with patient

- Establish the minimum number of interactions the CHW should have with the patient
- Define a timeline for which interactions between the CHW and the patient should occur and in what setting the CHW will interact with the patient

I. Draft and implement process for tracking patient progress on the care plan and making that information available to the primary care team

- Define standardized set of information to document on care plan during each patient interaction
- Establish timeframe within which CHW should update the care plan and create a progress note for the patient after every interaction
- CHWs should be responsible for collecting and tracking patient data (i.e.; progress note, updates to care plan, newly identified challenges/barriers) related to the care plan for the primary care practice
- Develop capabilities for care plan to be accessible to the primary care team
- Develop capabilities for the CHW to routinely communicate key information captured through patient interactions with the primary care team in between formal team meetings (e.g.; direct messaging)

2. Program Design Step 3: HEI Standards



The development of community linkages will be addressed by Design Group 2 (standards M-N)

Program evaluation parameters will be addressed by Design Group 3 (standard O)

J. Develop and execute relationships with housing, economic, and nutrition/food security assistance organizations for the Community Health Worker to draw on to execute the care plan

K. Draft and implement guidelines for connecting patients with other community resources with which the Advanced Network/FQHC does not have formal linkages

L. Develop program evaluation parameters and capabilities to be reviewed and updated on an annual basis [Will be Addressed by Design Group 3]

2. Program Design Step 4: HEI Implementation

Standards J-K Implementation Guidelines Will Be Addressed by Design Group 2

Standard L Implementation Guidelines Will Be Addressed by Design Group 3

2. Program Design Step 3: HEI Standards

6 **Patient Ready to Discontinue from CCIP Intervention**

Through the HEI program the patient has….

- ✓ Been connected to needed social support services
- ✓ Barriers to care have been addressed (e.g.; health literacy, culturally competent education, etc.)
- ✓ Developed self-management skills
- ✓ Achieved their goals on the shared care plan

How will the CHW and primary care team know when they patient no longer needs CHW support?

The patient will not continually need the support of the CHW and the AN/FQHC will have to develop a way to know when that is

Standard:

M. Develop or identify criteria to identify when patient can be discontinued from Health Equity Improvement Program

2. Program Design Step 4: HEI Implementation

M. Develop or identify criteria to identify when patient can be discontinued from Health Equity Improvement Program

Develop or identify evaluation tool that assess patient readiness for care self-management (e.g.; Client Perceptions of Coordination Questionnaire – CPCQ)

Are there other measures the PTTF is aware of that could evaluate a patient's readiness for self-management?

3. Case Study: VT Community Care Teams

The Vermont Community Care Teams similarly requires that the network design a team that integrates clinical and social services to comprehensively address the needs of more complex patients or patients experiencing gaps in services. However, Vermont's approach leaves flexibility to the network to do more detailed design.

Network Participation Requirements:

- Meet NCQA PCMH standard to do team based ongoing performance improvement
- Commit to designing a community health team that can represent the clinical and social needs of a patient
- Community health team should be made up of professionals embedded in the practice and the community
- Participation in VTs health information technology infrastructure

Participating Network Design Areas (i.e.; Networks Designed Based on Guidelines Provided):

- Allowed communities to evaluate biggest areas of needs/gaps
- Community care team composition varied based on the needs of each community (however, there were some team members common to all communities such as nurse coordinators and community health workers)
- How to identify patients in need of additional support – many do not use strict criteria, but informal assessments of needs during routine primary care visits

3. Case Study: Diabetes Care Among Latino Patients

The DIALBEST Trial was designed to address healthcare access and disease management disparities among Latinos with diabetes and serves as an example of a program with a very prescriptive design.

1 Identify Patients Experiencing Equity Gaps

- Latino patients with poorly controlled type 2 diabetes (specific inclusion/exclusion criteria)
- Identified pro-actively using EMR database

2 Connect Patient to Community Health Worker (CHW) Trained to Address Gap

- Identified pro-actively using EMR database
- Connected to CHW during primary care visit
- CHWs deployed from community based non-profit organization
- CHW had 65 hours of intensive training focused on type 2 diabetes pathophysiology and risk factors, lifestyle strategies for glycemic control, glucose self-monitoring, and medications
- Additional 25 hours on motivational interviewing, communication skills, and topics related to social determinants of health and cultural competence

3 CHW Conducts a Needs Assessment

- Interventions were individually tailored based on principles of behavioral change theory

Source: Perex-Escamila, R;, Damio G, Chhabra J, et al. Impact of community health workers – led structured program on blood glucose control among latinos with type 2 diabetes: the DIALBEST trial; Diabetes Care; 2014

3. Case Study: Diabetes Care Among Latino Patients

The DIALBEST Trial was designed to address healthcare access and disease management disparities among Latinos with diabetes and serves as an example of a program with a very prescriptive design.

4 CHW Develops a Care Plan Based on Needs Assessment

- At each visit the CHW and patient develop a self-management plan that takes into account language preference, socio-economic circumstances, clinical history, and previous challenges with type 2 diabetes self-management
- The stage of change of patient is also taken into consideration in developing the self-management plan

5 CHW Executes and Monitors Care Plan

Interaction with the Patient:

- **1st Month:** Weekly CHW visits in home
- **2nd/3rd Months:** Biweekly CHW visits in the home
- **4th-12th Month:** Monthly CHW visits in the home
- **13th-18th Month:** No home visits

Interaction with Primary Care Team:

- Weekly meetings with CHW supervisor and health management coordination team at the clinic (included primary care clinic medical team and dietician)
- Meetings used for CHW to inform team of barriers and identification of treatment options

Source: Perex-Escamila, R;, Damio G, Chhabra J, et al. Impact of community health workers – led structured program on blood glucose control among latinos with type 2 diabetes: the DIALBEST trial; Diabetes Care; 2014

3. Case Study: Diabetes Care Among Latino Patients

The DIALBEST Trial was designed to address healthcare access and disease management disparities among Latinos with diabetes and serves as an example of a program with a very prescriptive design.

5 **CHW Executes and Monitors Care Plan Contd.**

Data Collection:

- Assessment at 3, 6, 12, and 18 months of
  - Self-management knowledge, behavior, and attitudes
  - Blood collection for HA1c
  - Biomarkers measured
- Performance of CHW assessed – intake assessments, progress notes, and phone logs for patient contact

Discussion Question:

Considering both the VT Community Care Team approach and the DIALBEST approach, which level of specificity does this group think the CCIP recommendations should strive for?

Source: Perex-Escamila, R;, Damio G, Chhabra J, et al. Impact of community health workers – led structured program on blood glucose control among latinos with type 2 diabetes: the DIALBEST trial; Diabetes Care; 2014

4. Key Themes and Questions

- What key themes/decisions were surfaced during today's design session?

- Are there specific questions this design group would like to surface with the broader PTTF at the next meeting on 7/28?

5. Next Steps

- Summarize today's discussion and send to Design Group 1 for input
- Present summary of discussion to broader PTTF on 7/28

- Schedule additional design session to wrap up conversation on Comprehensive Community Care Teams and the Health Equity Improvement Program and review straw man for Behavioral Health Integration