DRAFT: Connecticut SIM Community and Clinical Integration Program Technical Assistance Standards

Focus Area: Comprehensive Community Care Teams

Program Definition and 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.

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 (Coalition, 2015; Health, 2014; Health Management Associates, 2012). 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 (Health Management Associates, 2012). 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 (Health Management Associates, 2012). Of particular importance are the social needs, often referred to as social determinants of health, which tend to negatively impact overall health outcomes (Hamblin, 2014). 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
  (sources: (Coalition, 2015; Health Management Associates, 2012))

Program Standards:

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

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

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

D. Establish analytic method and apply it to attributed patients within the X 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

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

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

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

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

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

Implementation Approach

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 (Coalition, 2015):
    - 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

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
      Sources: (Coalition, 2015) (Health, 2014) (Health Management Associates, 2012)
- 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 _____ resulting in _____certification
- Develop job descriptions for all comprehensive community care team members.
    - The CHW job description should include, at a minimum, the following key responsibilities (Health Management Associates, 2012):
        - 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 (Health Management Associates, 2012; Perez-Escamilla R, 2014):
        - Representative in some manner of the patient population they are supporting (e.g.; culturally, geographically, clinical profile, etc.)

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)

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 [Further developed by Design Group 3]**

- Describe method of analysis
- Identify data source(s) for analysis
- Generate list of attributed patients who are eligible for Comprehensive Community Care Team intervention and will be targeted for enrollment
- If applicable, generate list of eligible patients at least every _____ months

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 (Coalition, 2015; Health, 2014)

- 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

F. Develop a needs assessment that evaluates the patient's clinical, social, and behavioral needs [include sample needs assessment in appendix –TBD, inquiring with other states]

- 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 (NCQA, 2015)

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

H. Develop a standardized shared care plan to complete for each patient [provide example of a shared care plan – TBD reaching out to other states]

- 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

J. Draft and implement policies for comprehensive community care team meetings (Coalition, 2015) (Health Management Associates, 2012)

- 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

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)

M. Develop and execute relationships with x, y, z community based services (TBD) for the comprehensive community care team to draw on to execute care plan

- TBD by Design Group 2's work

N. Draft and implement guidelines for connecting patients with other community resources with which the Advanced Network/FQHC does not have formal linkages [Further developed/considered by design group 2]

- CHWs should maintain a list of relevant community resources for the patient population they are serving
- CHW is responsible for initiating the patient link to the needed resource and following up to ensure the patient received the necessary assistance
- Referrals made should be tracked in the shared care plan

O. Develop program evaluation parameters and capabilities to be reviewed and updated on an annual basis [Further considered/developed by Design Group 3]

- Develop process metrics reflective of process design that at a minimum include:
    - # of enrollees out of total eligible patients (% enrolled)
    - # of care plans completed for enrolled patients (% care plan completed)
    - # of in person visits with MDT members out of what guidelines recommended (% in person visits)/# of care coordination hours/# of CHW hours

- Develop outcome metrics reflective of program objectives that at a minimum should include relevant metrics aligned with quality score card:
    - 30 day readmissions
    - ASC admissions
    - ED use
- Establish process to share performance with program participants and develop process to utilize performance outcomes to inform ongoing performance improvement efforts

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) (Coalition, 2015)

References

Coalition, C. (2015, April 20). Camden Coalition Care Management Initiative. (Chartis, Interviewer)

Hamblin, A. (2014, March 24). Opportunity Knocks to Improve Care for "Super-Utilizers". n/a, n/a, n/a.

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Health, H. (2014). *Hennepin County Hennepin Health.* Hennepin: Hennepin County.

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Perez-Escamilla R, D. G. (2014). Impact of Community Health Workers - Led Structured Program on Blood Glucose Control Among Latinos with Type 2 Diabetes: The DIALBEST Trial. *Diabetes Care*, n/a.