Practice and Transformation Taskforce: CCIP

Design Group 3: Monitoring and Reporting

June 1st, 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. Overview of Population Definition & Identification, Monitoring and Reporting Needs	30 min
5. Next Steps	5 min

1. Meeting Objectives

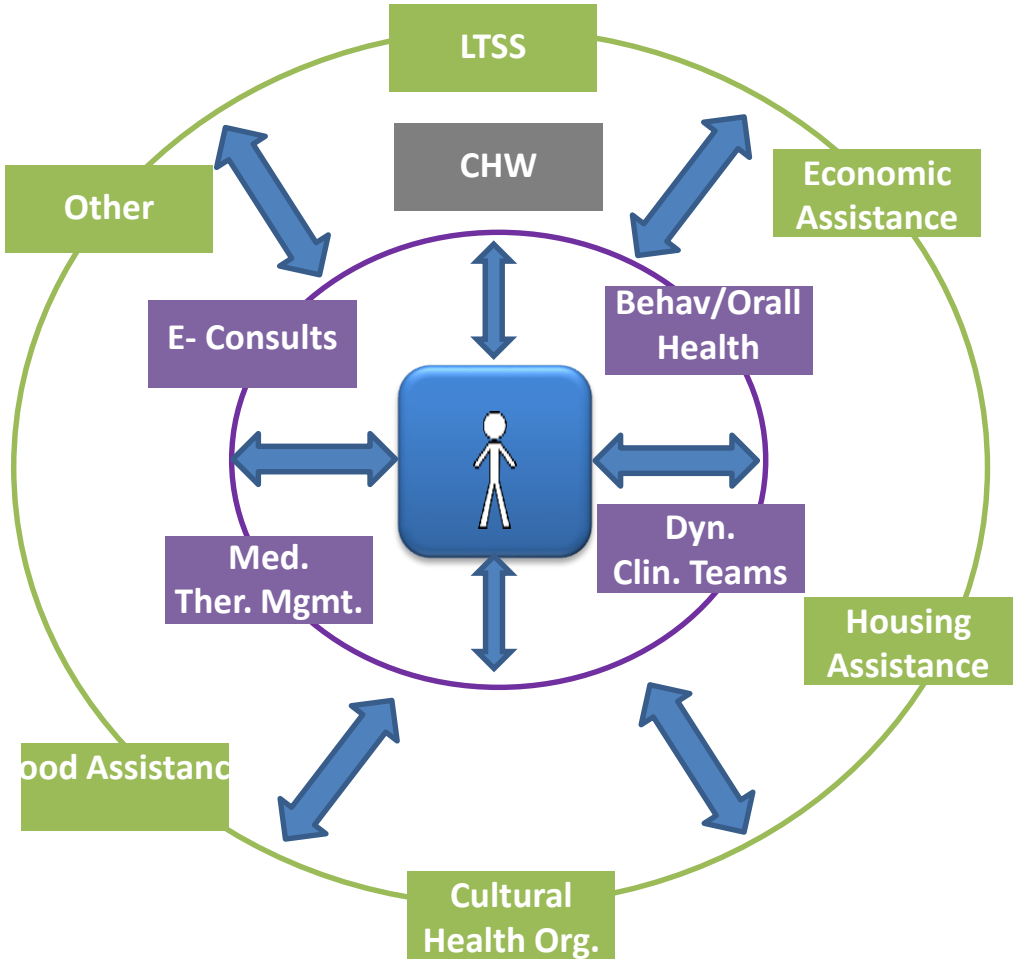
1. Agree on key success factors for CCIP participants

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

3. Gain understanding of population identification, monitoring and reporting needs

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**

REINVENTING MICHIGAN

- **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.

Proposed Solution

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

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%

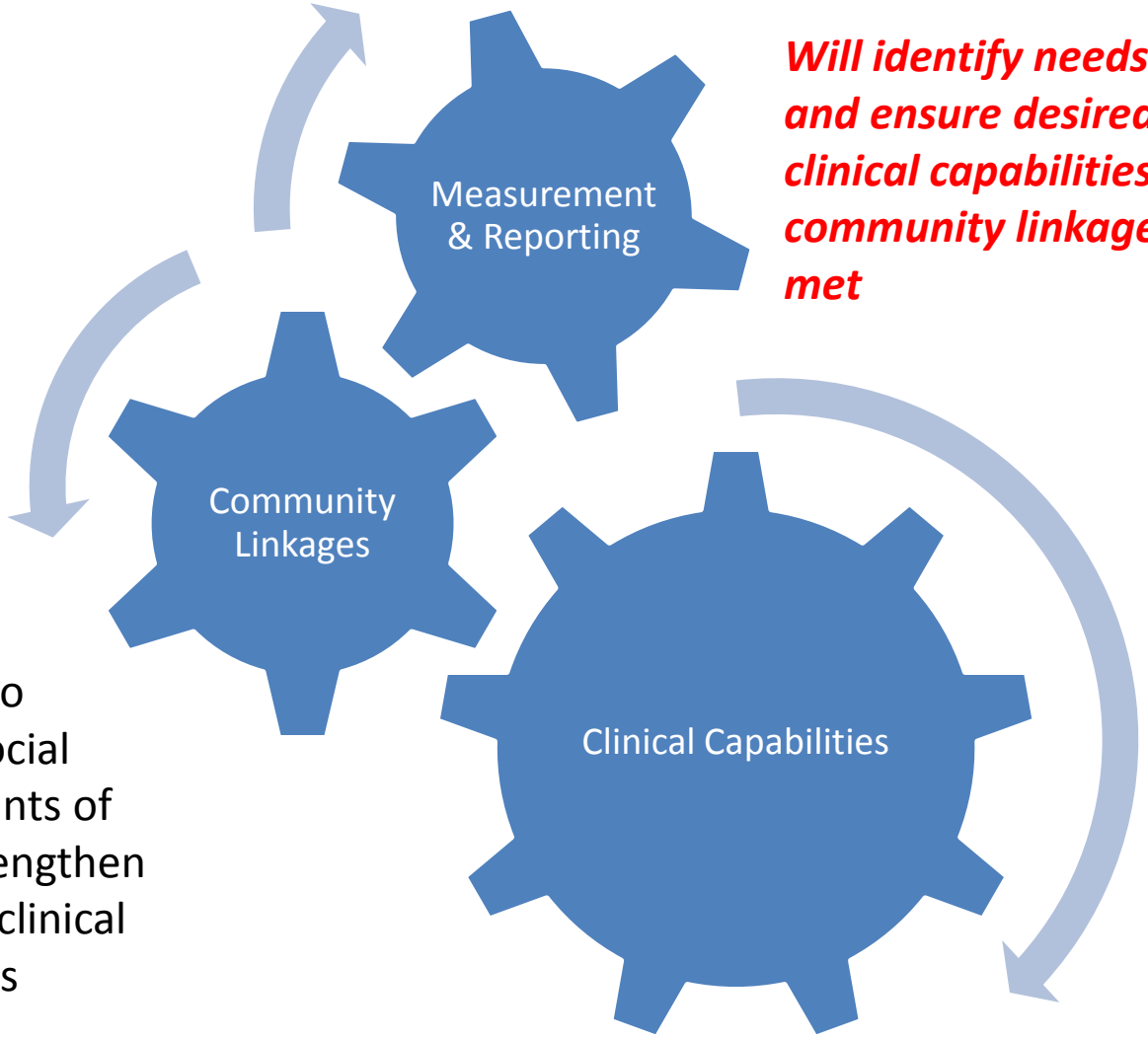
Notes: PCP counts include those PCPs employed by or affiliated with Advanced Networks and FQHCs; Targets are cumulative totals

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

Notes: Metrics have not been updated to reflect MQISSP timeline

3. Overview of CT SIM Goals and CCIP

While the CT SIM goals are geared toward improvement of health and health outcomes, achieving the goals will require support from outside the clinical space, which the CCIP initiative will help to address.



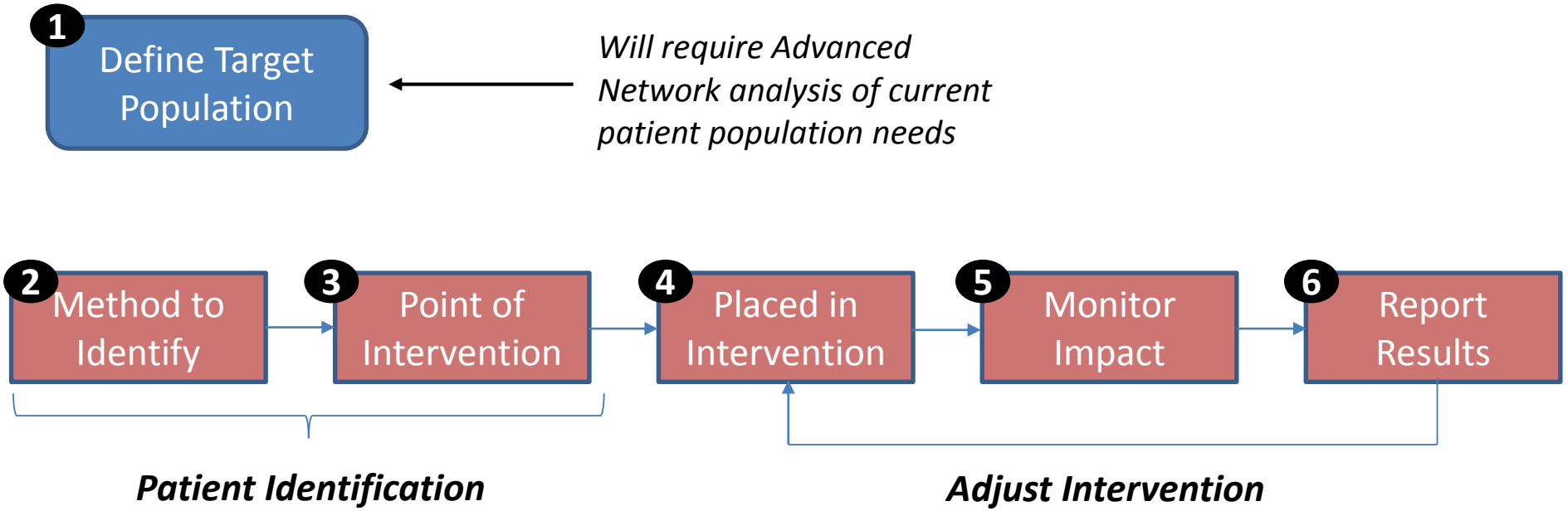
Will identify needs of population and ensure desired goals of clinical capabilities and community linkages are being met

Will help to address social determinants of health strengthen impact of clinical capabilities

Targeted clinical interventions that will drive toward CT SIM goals.

4. Identification, Monitoring and Reporting Needs

The focus of this design group will be to develop guidelines for defining the target population, a process to identify patients for intervention, and monitoring and reporting on the performance of the intervention.



4. Identification, Monitoring and Reporting Needs

1 Define Target Population

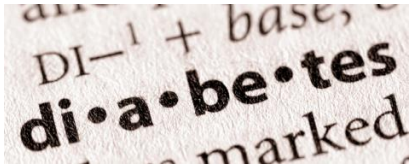
What guidelines should Advanced Networks follow to define their target population?

How should the population be defined?

Specific Geography

High Resource Utilizers

Populations Experiencing Equity Gaps



Specific Disease State

What supporting evidence should be provided?

- **<u>Community based data</u>**: local public health, hospital assessment, health system utilization, etc.
- **<u>Community input</u>** to understand consumer perspective of needs (*suggested by design group two*)
- **<u>Contributes to CT SIM goals,</u>** justification that working with this population will support broader CT SIM goals (e.g.; reducing health equity gaps, improving quality, cost, and access, etc.)

Discussion Questions:

- Are there other ways to define the population or supporting evidence *<u>not</u>* outlined here that should be considered?
- How proscriptive should the guidelines be?

4. Identification, Monitoring and Reporting Needs

2 Method to Identify

What guidelines should govern the process for identifying the target population?

What method will be used to identify the patient?

Examples from other models…

- Technology infrastructure to flag potentially eligible patients
  - # of admits to ED or Hospital over defined period of time
  - Pro-active identification through centralized data source; list shared with community entities that can intervene
  - All patients screened when seen in primary care setting
- Develop specific inclusion/exclusion criteria
  - Should there be a minimum requirement for inclusion (e.g.; readiness assessment)?
- Define data sharing requirements and associated implications (e.g.; EHR platform, direct messaging, etc.)

Discussion Questions:

- Should there be minimum requirements for the method to identify the population?
  - For example: All must have inclusion/exclusion criteria but how it is applied can vary (i.e.; via technology or manually through a survey)
- Should there be any required inclusion/exclusion criteria?
  - For example: Everyone should assess readiness?

4. Identification, Monitoring and Reporting Needs

3 Point of Intervention

What guidelines should govern the process for identifying the target population?

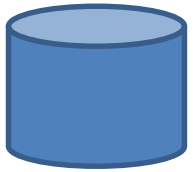
Where will the patient be identified? Why this location?

Hospital

ED

OP Setting (e.g.; FQHC, PCP)

Community Setting (e.g.; Soup Kitchen)



Centralized Data Source

Discussion Questions:

- What detail on the process should be provided on where patient's are identified?
  - How will patients be identified?
  - What communication is needed to facilitate process?
    - Where data sharing is necessary between entities – how much detail should be required on the process? What sort of contractual arrangements will need to exist?
  - What resources are needed to identify the patient (i.e.; people, technology)?
- Should justification be required for why the point of intervention chosen is the most appropriate?
  - For example: Camden Coalition identifies patients in the hospital because it supports targeting "super-utilizers" who may not be regularly interacting with a primary care physician

4. Identification, Monitoring and Reporting Needs

4 Placed in Intervention

5 Monitor Impact

How will the intervention impact monitoring? What guidelines should govern monitoring?

Intervention will be designed around patient and include different clinical and community capabilities:

Integration and Support of Providers Across the Continuum:
- **Behavioral and Oral Heath**
- **Medication Therapy Management**
- **Dynamic Clinical Teams**
- **E-consults**
- **Community Health Workers**

Integration with Other Services:
- **Long Term Support Services**
- **Economic Assistance**
- **Housing Assistance**
- **Cultural Health Organizations**
- **Food Assistance**

Each clinical capability and community linkage will have a set of associated process and outcome metrics.

Advanced Networks should be able to: Demonstrate ability to monitor designated process and outcome metrics using a standardized method (to be defined by design groups one and two)

Note: All Advanced Networks will be reporting on quality as defined by the CT SIM quality dashboard.

4. Identification, Monitoring and Reporting Needs

6 Report Results

What should the reporting guidelines be to ensure that the CCIP efforts are being actively monitored and used to inform process improvements where necessary?

CCIP Performance Dashboard/Scorecard

What?	CCIP specific performance metrics (process and outcome)
Why?	Promotes transparency, accountability, and performance improvement
Who?	Individual or committee responsible for reviewing on a pre-determined and consistent basis
Result?	Improvement opportunities identified and addressed

Discussion Questions:

- Who should be responsible for monitoring performance? Addressing barriers?
- How proscriptive should the guidelines be?

5. Next Steps

- Summarize discussion from today, share with group, and confirm accurate summary
- Share output with broader PTTF at 6/9 meeting
- Develop straw-man guidelines to review and test at next design group meeting on 6/23
- Incorporate feedback and formulate recommendations to present to broader PTTF on 6/30