Practice and Transformation Taskforce: CCIP

Design Group 3, Session 2: Technology Enablers & Monitoring Performance

August 20th, 2015

Meeting Agenda

Item	Allotted Time
1. Meeting Objectives	5 min
2. Design Group 3 Overview	10 min
3. Review of Technology & Reporting Needs and Associated HIT Solutions	70 min
4. Next Steps	5 min

1. Meeting Objectives

1. Review design group two objectives

2. Gain agreement on design group three relevant standards and identify programmatic needs for network implementation of standards

2. Design Group Three Overview

Design group three's charge is threefold:

1) **Define the minimum set of analytic capabilities required to identify target populations**
2) **Identify the needed technology to enable seamless communication between care team partners**
3) **Define requirements for monitoring and reporting capabilities**

2. Design Group Three Overview: Discussions To Date

1

Advanced Network & FQHC State of Technology:
At our last Design Group meeting on June 1, the group discussed whether or not Advanced Networks/FQHCs would have robust enough data capabilities to be able to define a target population.

2

Multi-payer Alignment:
The group highlighted the importance of aligned financial incentives through shared savings and a common quality scorecard for the CCIP work to be successful.

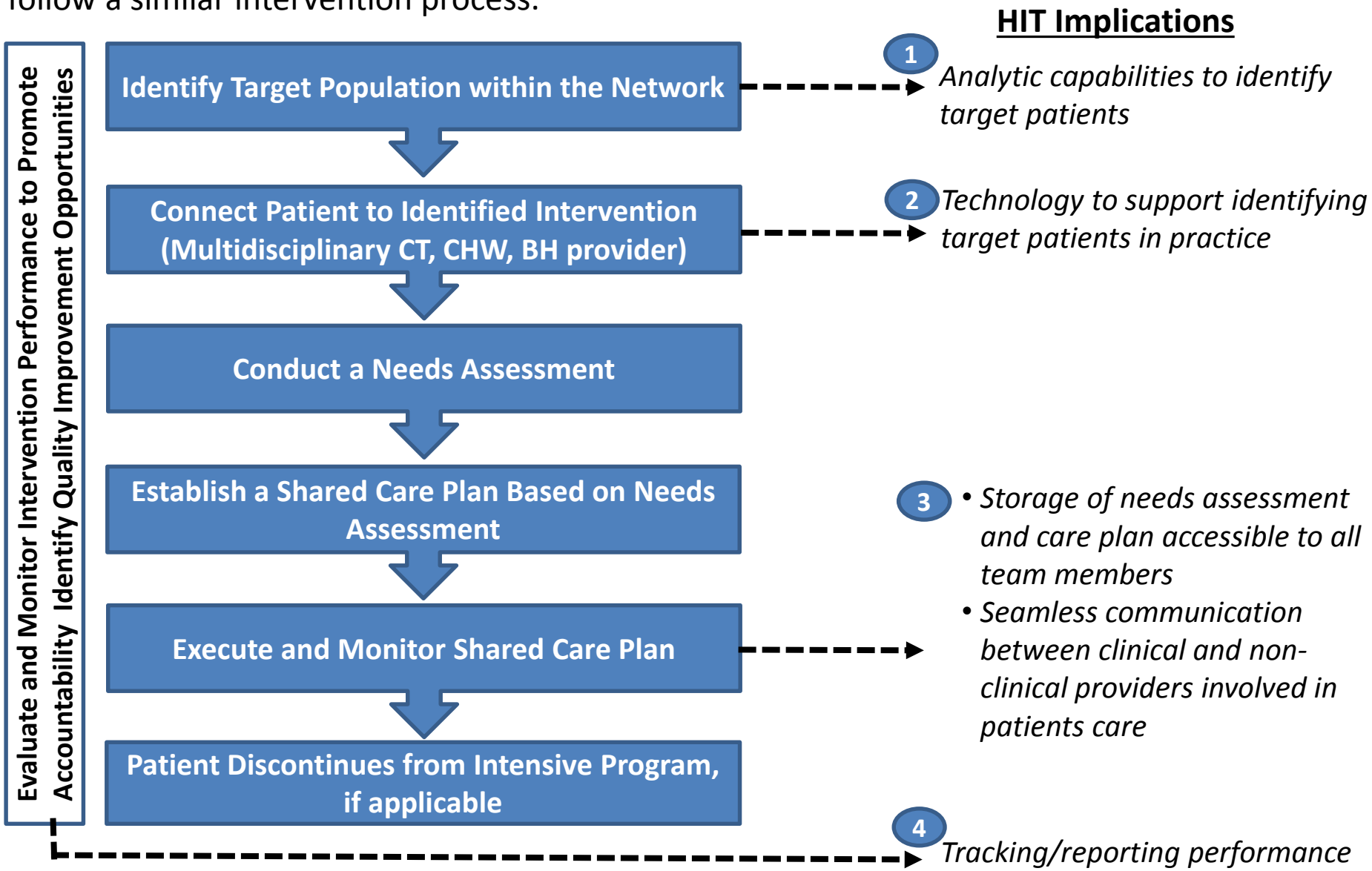
3

Design Group 3 Decision Points:

- Defining the target population
- Identifying the patient in practice
- Measuring and reporting on CCIP performance through the use of a dashboard

3. Technology and Reporting Needs

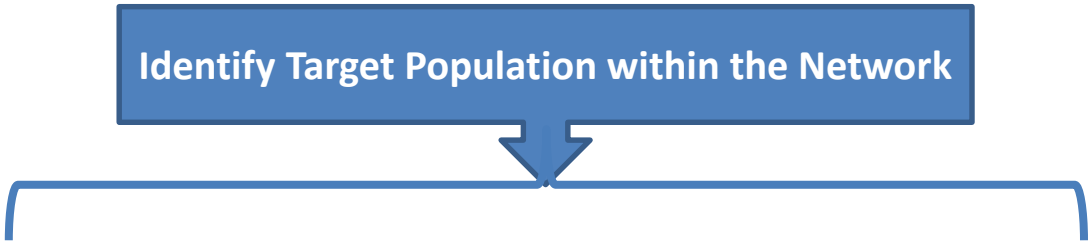
Even though there are three distinct target populations, at a high level each population will follow a similar intervention process.



3. Technology and Reporting Needs

Within all the areas where there are technology and reporting needs identified, the design group will have to develop recommendations on standards and identify the programmatic needs to achieve those standards.

Example

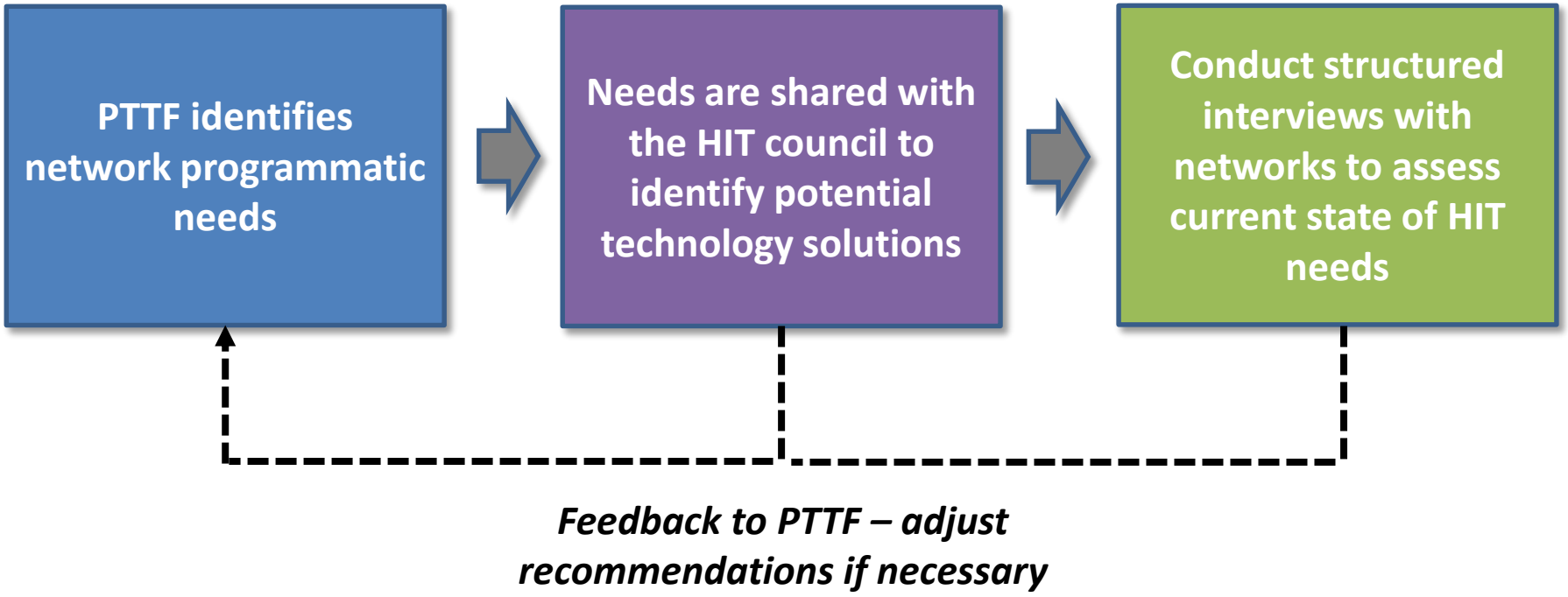


Standard (Complex Patients)	Associated Programmatic Need
A. Documented systematic identification process of eligible patients	A. Not applicable
B. At a minimum providers should deploy some type of basic analytic capabilities to risk stratify patients considering a combination of utilization data (claims) and clinical, behavioral, and social determinants of health data (EMR based). Networks should strive to use more complex analytics involving predictive modeling if possible.	B. Care management tool that aggregates utilization data (claims) and clinical data (EMR based) to support a risk stratification approach that incorporates all relevant risk factors (utilization, health status, behavioral and social factors)

3. Technology and Reporting Needs

As the council identifies the programmatic capabilities that will be required for networks to achieve the recommended standards, the requirements will be shared with the CT SIM HIT council to identify areas in which the HIT solutions are supportive of the identified needs.

Process for Working with HIT



3. Technology and Reporting Needs

In the last PTTF meeting there was agreement that the minimum standard of basic analytics should be met, but questions remain on the required capabilities for networks to carry this out.

Range of Options Requiring Varying Levels of Technology

	Referral	Manually Applied Criteria	Basic Analytics	Complex Analytics
Complex	• Based on professional judgement patient is flagged for program	• Manual method to flag high risk/complex patients developed (e.g.; > 2 IP admissions in 6 months) • Criteria applied in checklist form	• Risk stratification to identify high risk/potentially complex patients • Additional analysis if necessary to confirm "complex"[1]	• Predictive analytics to pre-emptively identify patients at risk for becoming complex
Equity Gaps		• Mining of claims data, chart review and physician referrals to identify gaps in care	• Stratify patients by OMB sub-populations[2] • Compare disease state outcomes	• Stratify patients by OMH sub-populations[2] • Compare disease state outcomes
Behavioral Health	N/A – patients will be identified through in person screening			

Questions:

- Basic analytics will require a care management tool that aggregates claims data and EMR data – do networks have these type of care management tools today?

Minimum

Optional

Notes: 1) Consider number of chronic conditions, access issues, social supports, homelessness, medications; 2) OMB are the basic 7 race categorizations and OMH includes more specific sub-population categorizations like gender, disability and literacy

3. Technology and Reporting Needs

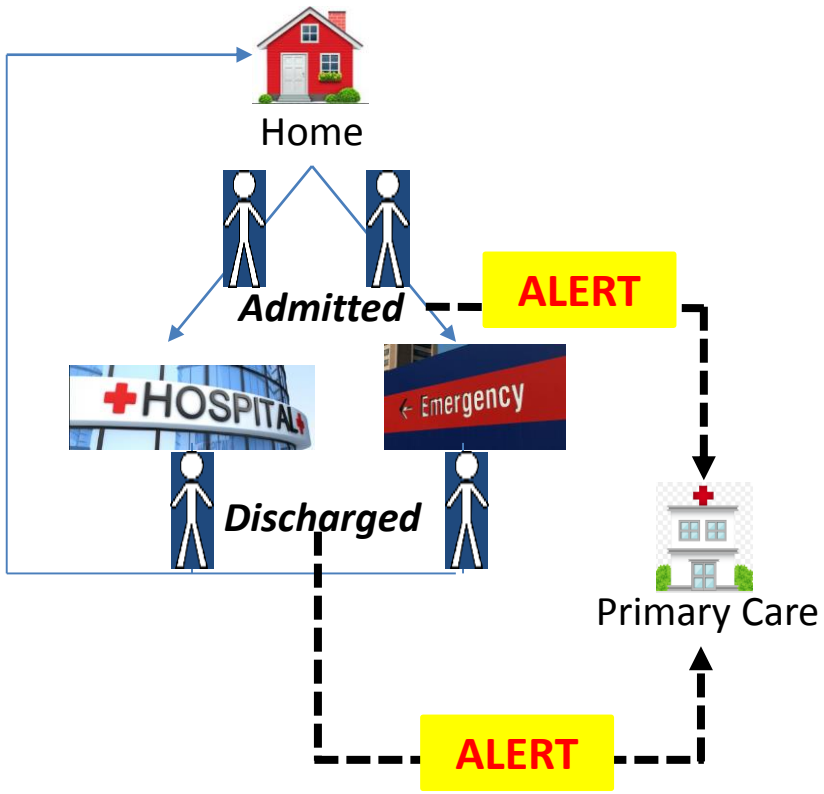
Identify Target Population within the Network

	Proposed Standard	Associated Programmatic Need
All	A. Documented systematic identification process of eligible patients	A. Not applicable
Complex	A1. At a minimum providers should deploy some type of basic analytic capabilities to risk stratify patients considering a combination of utilization data (claims) and clinical, behavioral, and social determinants of health data (EMR based). Networks should strive to use more complex analytics involving predictive modeling if possible.	A1. Care management tool that aggregates utilization data (claims) and clinical data (EMR based) to support a risk stratification approach that incorporates all relevant risk factors (utilization, health status, behavioral and social factors)
Equity	A2. At a minimum the network assess gaps in health outcomes by OMB racial categories (seven race categorizations) and the outcomes evaluated should be tied to metrics on the aligned quality scorecard (diabetes, asthma, and hypertension) [Consider NCQA ACO accreditation guidelines to further inform]	A2. Consistently capturing relevant sub-population categories in EMR to allow for appropriate stratification A2. Sufficient N to demonstrate statistical differences
Behavioral	A3. Administer behavioral health screening tool to all patients that flags potential behavioral health needs for which additional follow up is needed	A3. Technology to track screening, referrals, treatment and outcomes (e.g.; disease registry, EMR, etc.)

3. Technology and Reporting Needs

Many complex patients do not frequently interact with their primary care physicians, presenting a barrier to connecting patients to the CCIP resources.

Potential Technology Solution (ADT):



Benefit of Admission, Discharge, Transfer Technology:

- Admission, Discharge and Transfer (ADT) alert technology sends alerts to a patient's identified provider when the are admitted and discharged or transferred from a care setting
- This technology could be used to alert networks when a CCIP eligible patient is seeking care in the hospital or ED
- Beyond identifying CCIP patients, the technology can also alert providers when enrolled CCIP patients are in the hospital/ED and may need the care team's support

3. Technology and Reporting Needs

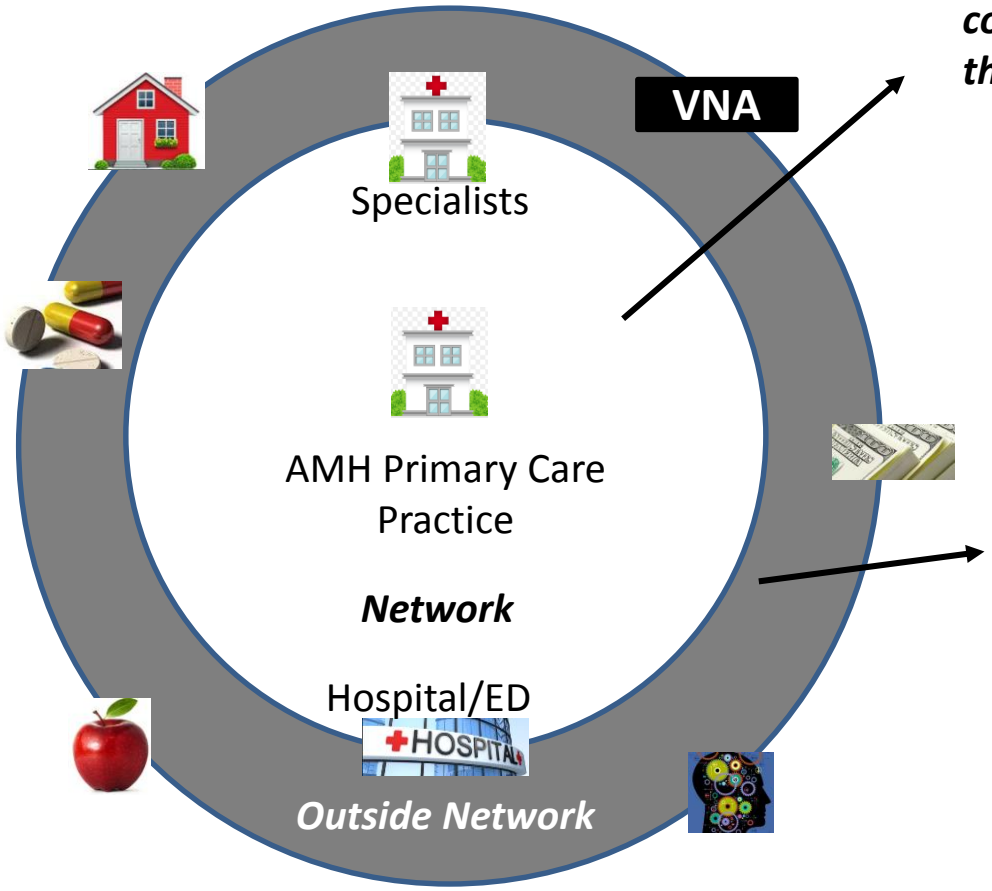
Connect Patient to Identified Intervention (Multidisciplinary CT, CHW, BH provider)

	Proposed Standard	Associated Programmatic Need
All	B. Draft and implement the process for connecting patients to the CCIP intervention	A. Not applicable
Complex	B1. There are a range of options for networks to establish this process from connecting the patient when he/she comes in for a primary care visit to connecting with the patient when they are in the ED/hospital to pro-actively reaching out to patients. The network should determine what is most appropriate for their patient population.	B1. System to push out an alert when an eligible patient is interacting with the healthcare system and there is an opportunity to connect them with the multidisciplinary care team
Equity	B1. There are a range of options for networks to establish this process from connecting the patient when he/she comes in for a primary care visit to connecting with the patient when they are in the ED/hospital to pro-actively reaching out to patients. The network should determine what is most appropriate for their patient population.	B1. System to push out an alert when an eligible patient is interacting with the healthcare system and there is an opportunity to connect them with the multidisciplinary care team
Behavioral	B2. Identify technology solution to track and confirm that the behavioral health referral was completed (i.e.; patient saw a behavioral health provider)	B2. Technology to track screening, referrals, treatment and outcomes (e.g.; disease registry, EMR, etc.)

3. Technology and Reporting Needs

Some of the patient's service or support providers will not be embedded in the network and may not be on the same EHR platform or will not have an EHR (e.g.; community organizations), but communication between these providers will be crucial.

Illustrative



Within the network seamless communication can likely be accomplished through the EHR platform

Communication Need	HIT Solution
✓All care team members have access to the care plan	Direct Messaging
✓Securely send relevant patient information to all care team members	Direct Messaging
✓Push notifications to team that care plan has been updated	ADT/Other
✓Incorporation of relevant detail into care team's respective EMR	TBD
✓Community partners can view relevant information, receive messages, and get notified when changes are made to the care plan	Direct Messaging/ Other TBD

Do Networks currently have any of these solutions?

3. Technology and Reporting Needs

Execute and Monitor Shared Care Plan

	Proposed Standard	Associated Programmatic Need
All	C. Care plans should be stored where they are accessible to all relevant members of the care team	C. Technology that allows access to/sharing of care plan across clinical and non-clinical entities (e.g.; portal, direct messaging)
Complex	C1. Care plan should be made accessible to all members of the multidisciplinary care team who reside in and outside the network	C1. Same as above
Equity	C2. Care plan should be made accessible to the community health worker who is working with the patient	C2. Same as above
Behavioral	C3. Care plan should be made accessible to the behavioral health provider, primary care, and any other relevant team member involved in supporting the referral process (e.g.; case manager)	C3. Same as above

3. Technology and Reporting Needs

Execute and Monitor Shared Care Plan

	Proposed Standard	Associated Programmatic Need
All	D. The organization has a documented process for exchanging health information across care settings which includes: • An agreement with care providers about exchanging information • The type of information to be exchanged • Time frames for exchanging information • How the organization facilitates referrals	D. Technology solution that allows for near-real time, seamless exchange of information between care providers inside and outside the network and tracking/follow-up on referrals
Complex	D1. Process standards TBD	D1. Same as above
Equity	D2. Process standards TBD	D2. Same as above
Behavioral	D3. Process standards TBD	D3. Same as above

3. Technology and Reporting Needs

For each CCIP intervention process and outcome metrics will be identified. The purpose of developing these metrics will enable networks to: 1) Evaluate whether or not the interventions are successfully meeting the CT SIM/CCIP objectives; 2) Identify opportunities for quality and process improvement; and 3) Promote accountability for patient care across all stakeholders

CCIP Performance Dashboard/Scorecard

Objective	How To Meet
1) Meeting CT SIM/CCIP Objectives	• Define CCIP process and outcome metrics – PTTF? Network? • Define which CT SIM metrics are relevant for each interventions • Method to monitor process/outcomes only for patients in intervention
2) Identify quality improvement opportunities	• Regularly monitor CCIP performance through use of a dashboard/scorecard • Identify individual(s) responsible for review and identification of improvement opportunities
3) Accountability across stakeholders	• Forum for sharing performance across all stakeholders – publicly made available? Reviewed at monthly meetings? • Define stakeholder expectations: which metrics are stakeholders responsible for?

3. Technology and Reporting Needs

Evaluate and Monitor Intervention Performance to Promote Accountability Identify Quality Improvement Opportunities

	Proposed Standard	Associated Programmatic Need
All	E. The organization has identified relevant process and outcome metrics for the CCIP interventions and has a process in place to monitor, report and hold relevant stakeholders responsible for performance	E. Technology solution that enables performance tracking on process and outcome metrics and tool to summarize and report performance (e.g.; dashboard or scorecard)
Complex	E1. Process standards TBD	E1. Same as above
Equity	E2. Process standards TBD	E2. Same as above
Behavioral	E3. Process standards TBD	e3. Same as above

4. Next Steps

- Draft initial set of standards and programmatic needs for the design group to review and provide feedback on

- Share guidelines with broader PTTF at 9/1 meeting