

CONNECTICUT HEALTHCARE INNOVATION PLAN



Connecticut State Innovation Model (SIM)
Report of the Practice Transformation Taskforce on
Community and Clinical Integration Program Standards
for Advanced Networks and Federally Qualified Health Centers
May, 2016

CORE STANDARDS

**CORE STANDARD 1:
COMPREHENSIVE CARE MANAGEMENT (CCM)**

FOCUS POPULATION: INDIVIDUALS WITH COMPLEX HEALTH CARE NEEDS

Individuals with Complex Health Care Needs: Individuals who have one or more serious medical conditions, the care for which may be complicated by functional limitations or unmet social needs, and who require care coordination across different providers, community supports and settings to achieve positive healthcare outcomes.

Program Description and Objective:

Description: Complex care management is a person-centered process for providing care and support to individuals with complex health care needs. The care management is provided by a multi-disciplinary *comprehensive care team* comprised of members of the primary care team and additional members, the need for which is determined by means of a person centered needs assessment. The comprehensive care team will focus on further assessing the individual’s clinical and social needs, developing a plan to address those needs, and creating action steps so that the individual is both directing and involved in managing their care.

The standards for comprehensive care management are intended to supplement existing medical home and care coordination programs in Connecticut. The standards will enable medical homes to identify more effectively individuals who would benefit from comprehensive care management, engage those individuals in self-care management, and coordinate services by means of expanded care team that includes community-based service and support providers. The comprehensive care management process may introduce additional components to the individual’s care plan, which will be coordinated as the individual progresses through the program. The ability of participating providers to meet the standards through existing programs vs. the need to develop supplemental capabilities, will be determined by means of a readiness review or gap analysis conducted with the assistance of the transformation vendor at the start of the program.

Person-Centered Definition: Person-centered care engages patients as partners in their healthcare and focuses on the individual’s choices, strengths, values, beliefs, preferences, and needs to ensure that these factors guide all clinical decisions as well as non-clinical decisions that support independence, self-determination, recovery, and wellness (quality of life). The individual engages in a

Objective: The objective is to comprehensively address identified barriers to care and healthy living and engage the individual directly in the direction and management of their care.

High-Level Intervention Design:

- 1. Identify individuals with complex health care needs**
- 2. Conduct person-centered assessment**
- 3. Develop an individualized care plan**
- 4. Establish a comprehensive care team**
- 5. Execute and monitor the individualized care plan**

- 6. Identify whether individuals are ready to transition to self-directed care maintenance and primary care team support**
- 7. Monitor individuals to reconnect to comprehensive care team when needed**
- 8. Evaluate and improve the effectiveness of the intervention**

1. Identify individuals with complex health needs

- a. The network identifies individuals with complex health needs who will benefit from the support of a comprehensive care team using an analytics-based risk stratification methodology that identifies current and rising risk and takes into consideration utilization data (claims-based); clinical, behavioral, and social determinant data (EMR-based); and provider referral. Integration with and use of external data sources (e.g., Homeless Management Information System, state agency data) is also recommended.
- b. The network has a process to electronically alert the medical home care team of the identified individuals with complex health needs that meet or exceed risk thresholds.

2. Conduct person-centered assessment

- a. To understand the historical and current clinical, social and behavioral needs of the individual, which will inform the individualized care plan, the network conducts a person-centered needs assessment with individuals identified in standard 1. The assessment includes:
 - i. Preferred language (spoken and written)
 - ii. Family/social/cultural characteristics including sources of support
 - iii. Assessment of health literacy
 - iv. Social determinant risks
 - v. Personal preferences, values, needs, and strengths
 - vi. Assessment of behavioral health needs, inclusive of mental health, substance abuse, and trauma
 - vii. Functional assessment
 - viii. Reproductive health needs
 - ix. The primary and secondary clinical diagnoses that are most challenging for the individual to manage
- b. Network defines processes and protocols for the conduct of a person-centered needs assessment that defines:
 - i. Where the person-centered needs assessment takes place
 - ii. The timeframe within which the person-centered needs assessment is completed
 - iii. The appropriate staff member to conduct the initial assessment

3. Develop an individualized care plan

- a. The comprehensive care team including the individual and their natural supports¹ collaborate to develop the individualized care plan² that reflects the person-centered needs assessment and includes the following features:
 - i. Reflects the individual's values, preferences, clinical outcome goals, and lifestyle goals
 - ii. Establishes clinical care goals related to physical and behavioral health needs
 - iii. Establishes social health goals to address social determinant risks

¹ Natural supports include but are not limited to, family, clergy, friends, and neighbors

² See Appendix F for examples of person-centered care coordination plans

- iv. Identifies referrals necessary to address clinical and social health goals and a plan for linkage and coordination
- b. The network defines a process and protocol for the comprehensive care team to create the individualized care plan including location, timeframe for completion, the lead team member responsible for creating the care plan, and frequency of follow-up meetings to update the care plan, if needed

4. Establish a comprehensive care team

- a. The network develops a comprehensive care team capability that specifically addresses the individual needs of the patient in accordance with the individualized care plan
- b. The network implements a process to connect individuals to a comprehensive care team such as:
 - i. During the primary care visit
 - ii. During an ED visit or inpatient hospital stay
 - iii. Pro-actively reaching out to the individual identified through analytics or registry data³
- c. The comprehensive care team fulfills several functions including clinical care management and coordination, community focused care coordination to link individuals to needed social services and supports, and culturally and linguistically appropriate self-care management education.
- d. The network ensures that each care team:
 - i. designates a lead care coordinator with responsibility for facilitating an effective comprehensive care team process and ensuring the achievement of the individual's lifestyle and clinical outcome goals.
 - ii. has the capability to add a community health worker to fulfill community-focused coordination functions
 - iii. has timely access to or has a comprehensive care team member who is a licensed behavioral health specialist capable of a conducting a comprehensive behavioral health assessment
 - iv. adds comprehensive care team members outside of the above core functions (e.g., dietitians, pharmacists, palliative care practitioners, etc.) on an as needed basis depending on the needs identified in the person-centered assessment
- e. The network ensures that practices have a documented policy and procedure for integrating additional comprehensive care team members. Options include:
 - i. Contracted or employed staff that reside within each primary care practice or in one or more hubs that support multiple practices
 - ii. Coordination protocols for integrating affiliated clinical staff (e.g., specialists)
 - iii. Contracted support from community organizations (e.g., CHW staff)
 - iv. Collaborative agreements with clinical partners (e.g., home care)
- f. The network establishes the appropriate case load (patient to team ratio) for comprehensive care teams based on local needs
- g. The network establishes training protocols related to:
 - i. Identifying values, principles and goals of the comprehensive care team intervention

³ Experience in other states suggest that the individual who is pro-actively reaching out to individuals should be someone they identify with and who can build rapport with them (e.g., a peer support or CHW) (Center for Healthcare Solutions, 2015)

- ii. Re-designing the primary care workflows that to integrate the comprehensive care team work processes
- iii. Orienting the primary care team to the roles and responsibilities of the additional care team members that form the comprehensive care team
- iv. Basic behavioral health training appropriate for all comprehensive care team members
- v. Motivational interviewing (required for the care coordinator, recommended for other primary care team members as appropriate)
- vi. Delivering culturally and linguistically appropriate services consistent with Department of Health and Human Services, Office of Minority Health, CLAS standards, including the needs of individuals with disabilities
- h. The network ensures that training is provided:
 - i. To all practice staff that are part of or engage with the comprehensive care team
 - ii. On an annual basis to incorporate new concepts and guidelines and reinforce initial training
- i. The network develops and administers CHW training protocols or ensures that CHWs have otherwise received such training:
 - i. Person-centered assessment
 - ii. Outreach methods and strategies
 - iii. Effective communication methods
 - iv. Motivational interviewing
 - v. Health education for behavior change
 - vi. Methods for supporting, advocating and coordinating care for individuals
 - vii. Public health concepts and approaches⁴
 - viii. Community capacity building (i.e.; improving ability for communities to care for themselves) (Boston, 2007)
 - ix. Maintaining safety in the home
 - x. Basic behavioral health training to enable recognition of behavioral health needs

5. Execute and monitor individualized care plan

- a. The network establishes protocols for regular comprehensive care team meetings that establish:
 - i. Who is required to attend⁵
 - ii. The frequency of the meetings
 - iii. The format of the meetings (i.e.; via conference call, in person, etc.)
 - iv. A standardized reporting form on the individual's progress and risks
- b. The network establishes protocols for monitoring individual progress on the individualized care plan, reporting adverse symptoms to the care team, supporting treatment adherence, and taking action when non-adherence occurs or symptoms worsen. The protocol includes:
 - i. Establishing key touch points for monitoring and readjusting the individualized care plan, as necessary
 - ii. Establishing who from the comprehensive care team will be involved in the touch points
 - iii. Developing a standardized progress note that documents key information obtained during the touch points

⁴ This includes common public health trends including the social determinants of health as well as awareness of conditions that are frequently unaddressed including reproductive health, oral health, behavioral health, etc.

⁵ Best practice suggests all members of the comprehensive care team and relevant primary care team members

- iv. Engaging the individual patient and caregivers in a plan to meet self-directed care management goals
 - c. The network modifies its process for exchanging health information across care settings to accommodate the role and functions of the comprehensive care team
 - Establishing the necessary agreements with providers with whom information will be exchanged, identifying the type of information to be exchanged, timeframes for exchanging information, and how the organization will facilitate referrals
 - d. The network establishes a technology solution and/or protocols with local hospital and facility partners to alert the primary care provider and comprehensive care team when a patient is admitted or discharged from an ED, hospital, or other acute care facility to support better care coordination and care transitions
 - e. The network establishes a process and protocols for accessing an up-to-date resource directory (such as United Way 211), connecting individuals to needed community resources (i.e.; social support services), tracking referrals, and tracking barriers to care, and providing facilitation to address such barriers (i.e., rides to appointments).
- 6. Identify when the individual is ready to transition to self-directed care maintenance and primary care team support**
- a. The network has a process for the comprehensive care team to collaborate with the individual to assess readiness to independently self-manage and transition to routine primary care team support⁶
 - b. The process includes examination of options to connect the individual to ongoing community supports such as a peer support resource
- 7. Monitor individuals to reconnect to comprehensive care team when needed**
- a. The network establishes a mechanism to:
 - i. monitor and periodically re-assess transitioned individuals (ideally every 6-12 months)
 - ii. notify the comprehensive care team when the individual has a change of condition or circumstances that require a reconnection to the comprehensive care team⁷
- 8. Evaluate and improve the effectiveness of the intervention**
- a. The network demonstrates that the comprehensive care team is improving healthcare outcomes and care experience for complex individuals by:
 - i. Tracking aggregate clinical outcome, individual care experience, and utilization measures that are relevant to the focus population's needs (i.e.; complex individuals)⁸
 - ii. Achieving improved performance on identified measures
 - b. The network identifies opportunities for quality process improvement. This will require:
 - i. Defining process and outcome measures specific to the comprehensive care team intervention
 - ii. Developing training modules for the care team, community supports, and patients/families

⁶ See Appendix F for sample tool

⁷ The network could consider utilizing a ED/Inpatient admission/discharge alert technology for monitoring

⁸ Clinical measure and experiences measures for complex individuals should be determined based on the most prevalent clinical areas of need for the network's complex individuals (e.g., behavioral health) and lower performing experience measures; utilization measures will likely include inpatient admissions for ambulatory sensitive conditions, readmissions, and ED utilization

- iii. Establishing a method to share performance⁹ data regularly with comprehensive care team members and other relevant care providers to identify opportunities for improvement
- iv. Conducting root cause analyses for to understand and address areas of under-performance using clinical data and input from the focus population¹⁰
- c. The network implements at least one additional network capability to support the comprehensive care team process.

⁹ Performance is commonly shared through a dashboard or scorecard. Networks should also consider establishing learning collaboratives that bring together the different practices in their network to share best practices

¹⁰ Input can be solicited in a number of ways, including, but not limited to a community advisory board, a focus group, existing community meetings or community leadership

CORE STANDARD 2: HEALTH EQUITY IMPROVEMENT

PART 1: CONTINUOUS QUALITY IMPROVEMENT STANDARDS FOCUS POPULATION: INDIVIDUALS EXPERIENCING EQUITY GAPS

INTRODUCTION

The Health Equity Improvement standards are divided into two parts. Part 1 focuses on the continuous equity gap improvement including the analytic capabilities to routinely identify disparities in care, conduct root cause analyses to identify the best interventions to address the identified disparities, and develop the capabilities to monitor the effectiveness of the interventions. These standards also require that the organization undertake a pilot health equity improvement intervention. The standards contained in Part 2 specify an intervention that utilizes the support of a community health worker (CHW) to address equity gaps. CHWs are a component of the pilot intervention because research has demonstrated that they can be effective and because their integration in the care process presents special challenges that the technical assistance process is intended to address.

Program Description and Objective:

Description: Continuous quality improvement standards are intended to provide a standardized process for networks to use data to identify and address healthcare disparities.

Objective: Provide Advanced Networks and Federally Qualified Health Centers (FQHCs) with a set of data/analytic standards that will enable them to identify disparities in care on a routine basis, prioritize the opportunities for reducing the identified disparities, design and implement interventions, scale those interventions across networks, and evaluate the effectiveness of the intervention.

High-Level Intervention Design:

1. **Expand the collection, reporting, and analysis of standardized data stratified by sub-populations**
 2. **Identify and prioritize opportunities to reduce a healthcare disparity**
 3. **Implement a pilot intervention to address the identified disparity**
 4. **Evaluate whether the intervention was effective**
 5. **Other organizational requirements**
1. **Expand the collection, reporting, and analysis of standardized data stratified by sub-populations**
 - a) The network implements a plan to collect additional race and ethnicity categories for its patient population. The selection of additional categories must:
 - i. Draw from the recognized “Race & Ethnicity—CDC” code system in the PHIN Vocabulary Access and Distribution System (VADS)) or a comparable alternative;
 - ii. Have the capacity to be aggregated to the broader OMB categories;
 - iii. Be representative of the population it serves, validated by (a) data (e.g., census tract data, surveys of the population) and; (b) input from community and consumer members if the network is implementing fewer than the 900+ available categories
 - b) It is recommended that the network also implements a strategy to routinely collect information regarding sexual orientation and gender identity.

- c) The network identifies valid clinical and care experience performance measures to compare clinical performance between sub-populations. Such measures:
 - i. Maximize alignment with the CT SIM quality scorecard;
 - ii. Include, at a minimum, the race/ethnicity categories identified in 1a. and preferred language;
 - iii. Are quantifiable and address outcomes rather than process whenever possible;
 - iv. Meet generally applicable principles of reliability, validity, sampling and statistical methods.
- c) The network analyzes the identified clinical performance and care experience measures stratified by race/ethnicity, language, other demographic markers such as sexual orientation and gender identity, and geography/place of residence.
- d) The network establishes methods of comparison between sub-populations
 - i. Clinical outcome and care experience measures are compared internally against the networks attributed population or to a benchmark¹¹
 - ii. Stratification by race/ethnicity/language is informed by the demographics of the population served by the network
- e) The network conducts a workforce analysis that includes analyzing the panel population in the service area, evaluating the ability of the workforce to meet the population’s linguistic and cultural needs, and implementing a plan to address workforce gaps

2. Identify and prioritize opportunities to reduce healthcare disparities

- a) The network documents and makes available to the technical assistance vendor the results of the opportunities identified through data analysis
- b) The network develops a process to prioritize opportunities. Prioritization considers:
 - Significance to individuals in the sub-population experiencing a disparity in care, which is evaluated through engaging members of the sub-population to prioritize opportunities

3. Implement at least one intervention to address the identified disparity (see Part 2)

- a) The network conducts a root cause analysis for the disparity identified for intervention and develops an intervention informed by this analysis
- b) The root cause analysis utilizes:
 - i. Relevant clinical data
 - ii. Input from the focus sub-population for whom a disparity was identified
 - iii. Input from the focus sub-population solicited through various venues
- c) The network designs a pilot intervention and describes how the intervention will meet the needs/barriers identified in the root cause analysis
- d) The network involves members of the sub-population who are experiencing the identified disparity in the design of the interventions
- e) The network implements an intervention in at least five practices

4. Evaluate whether the intervention was effective

- a) The network demonstrates that the intervention is reducing the healthcare disparity identified by:

¹¹ Networks not performing well against a national/regional benchmark may want to consider starting by comparing internally while networks with little disparity between in-network sub-populations may benefit from utilizing a benchmark.

- i. Tracking aggregate clinical outcome and care experience measures aligned with the measures used to establish that a disparity existed
- ii. Achieving improved performance on measures for which a disparity was identified
- iii. Sharing evaluation findings with the focus sub-population
- b) Identify opportunities for quality and process improvement. This will require:
 - i. Defining process and outcome measures for the interventions pursued
 - ii. Establishing a method to share performance¹² regularly with relevant care team participants to collectively identify areas for improvement

5. Other Organizational Requirements

- a) The network establishes culturally and linguistically appropriate goals, policies and management accountability, and infuses them throughout the organizations' planning and operations
- b) The network informs all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing
- c) The network ensures the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided

¹² Performance is commonly shared through a dashboard or scorecard. Networks should also consider establishing learning collaboratives that bring together the different practices in their network to share best practices

CORE STANDARD 2: HEALTH EQUITY IMPROVEMENT

PART 2: HEALTH EQUITY INTERVENTION PILOT

Program Description and Objective:

Description: The health equity pilot intervention will focus on:

- Identifying social, cultural and health literacy factors that might compromise health care engagement, experience and outcomes
- Standardizing elements of the care processes to be more culturally and linguistically appropriate such as by producing translated and culturally appropriate educational materials
- Using a community health worker who has culturally and linguistically sensitive training to educate individuals about their condition, empower them to better manage their own care, and providing community focused care coordination to link individuals to needed social services and supports
- Re-engineering processes to optimize performance and minimize sub-population specific barriers in the care pathway

For the pilot, networks will be encouraged to focus on sub-populations defined by race, ethnicity, and/or language and one of three conditions (diabetes, hypertension and asthma) that are included in the SIM Core Quality Measure set. The network may propose an alternative area of focus based on the network's demographics and performance data. Networks are encouraged to pilot the intervention in at least five practices or a large clinic setting.

The primary purpose of the intervention is to develop these skills with a focus sub-population and condition so that these same skills can then be applied to other sub-populations and conditions. It is expected that the Advanced Networks and FQHCs will examine their performance with smaller sub-populations such as Southeast Asian or Cambodian populations and adopt similar methods to close health equity gaps.

Objective: Narrow the gap in identified health care outcome and maintain improvement. Use the services of a community health worker to support the initial improvement and long-term maintenance of health outcomes for the sub-population identified through the provision of culturally sensitive medical education about their condition, behavior change education to promote a healthy lifestyle, and identifying and connecting the individual to needed support services.

High-Level Health Equity Gap Intervention Design:

1. **Create a more culturally and linguistically sensitive environment**
2. **Establish a CHW capability**
3. **Identify individuals who will benefit from CHW support**
4. **Conduct a person-centered needs assessment**
5. **Create a person-centered self-care management plan**
6. **Execute and monitor the person-centered self-care management plan**
7. **Identify process to determine when an individual is ready to transition to self-directed maintenance**

1. Create a more culturally and linguistically sensitive environment

The identified practices provide culturally and linguistically appropriate services informed by the root-cause analysis conducted in relation to the identified healthcare disparity.

- i. Practices provide interpretation/bilingual services as necessary
- ii. Practices provide printed materials (education and other materials) that meet the language and literacy needs of the individuals that comprise the focus population

2. Establish a CHW capability

- a. The network determines the best strategy for incorporating community health workers and community health worker field supervisor(s) into the primary care practices. Options include:
 - i. Employ the CHWs/CHW field supervisor within the practice
 - ii. Employ the CHWs/CHW field supervisor at one or more hubs in support of multiple practices
 - iii. Contract with community organizations for CHW/CHW field supervisor services
- b. The network documents process for how CHWs will be made available to individuals identified for the intervention
- c. The network establishes the appropriate case load for the CHW
- d. The network establishes training protocols on:
 - i. Identifying values, principles, and goals of the CHW intervention
 - ii. Redesigning the primary care workflow to integrate the CHWs work process
 - iii. Orienting the primary care team to the roles and responsibilities of the community health worker
- e. The network ensures training is provided:
 - i. To all primary care team members involved in the CHW intervention
 - ii. On an annual basis to incorporate new concepts and guidelines and reinforce initial training
- f. The network develops and administers CHW training protocols or ensures that CHWs involved in the intervention receive or have received disease-specific training based on the intervention, in addition to the core competency training outlined in CCM standard.

3. Identify individuals who will benefit from CHW support

- a. Network identifies individuals who will benefit from CHW support by developing criteria that assesses whether an individual:
 - i. Is part of the focus sub-population for the intervention
 - ii. Has a lack of health status improvement for the targeted clinical outcome
 - iii. Has cultural, health literacy and/or language barriers
 - iv. Has social determinant or other risk factors associated with poor outcomes
- b. Network has a process to electronically alert the medical home care team of the identified individuals that meet criteria for health equity intervention.

4. Conduct a person-centered needs assessment

- a. To understand the historical and current clinical, social and behavioral needs of the individual, the network conducts a person-centered needs assessment with individuals identified for the intervention. The assessment includes:
 - i. Preferred language
 - ii. Family/social/cultural characteristics

- iii. Behaviors affecting health
- iv. Assessment of health literacy
- v. Social determinant risks
- vi. Personal preferences and values
- b. Network defines the process and protocols for the CHW to conduct the person-centered needs assessment¹³

5. Create a person-centered self-care management plan

- a. The CHW and the individual and their natural supports¹⁴ collaborate to develop a self-care management plan based on the results of the person centered assessment. The care plan includes the following features:
 - i. Incorporates the individual’s values, preferences and lifestyle goals
 - ii. Establishes health behavior goals that will improve self-care management and are reflective of the individual’s stage of change¹⁵
 - iii. Establishes social health goals that will improve self-care management and are reflective of needs/barriers identified in the person-centered needs assessment
 - iv. Identifies actions steps for each goal and establishes a due date¹⁶
- b. The network defines a process and protocols for the CHW to create the person-centered self-management plan including location and timeframe for completion¹⁷

6. Execute and monitor the self-care management plan

- a. The network establishes protocols for regular care team meetings that establish:
 - i. Who is required to attend¹⁸
 - ii. The frequency of meetings
 - iii. The format for the meetings (i.e.; via conference call, in person, etc.)
 - iv. A standardized reporting structure on the individual’s progress and risks¹⁹
- b. The network establishes protocols for monitoring individual progress on the self-care management plan the includes:
 - i. Establishing key touch points with the individual for monitoring and readjusting of the person-centered self-care management plan, as necessary
 - ii. Establishing who, in addition to the CHW, will be involved in the touch points
 - iii. Developing a standardized progress not that documents key information obtained during the touch points

¹³ Should identify where the person-centered needs assessment should be conducted which should be determined by the patient and the timeframe within which it should be completed post CHW intervention enrollment

¹⁴ Natural supports include but are not limited to, family, clergy, friends, and neighbors

¹⁵ Stage of change refers to the Prochaska’s stages of change model that categorizes how ready an individual is to change their behavior. Stages include: pre-contemplation (not ready), contemplation (getting ready), preparation (ready), action, and maintenance

¹⁶ See Appendix F for examples from other programs

¹⁷ The network should determine where the self-care management plan should be completed which should be determined by the patient and a timeframe for completion post needs assessment should be established

¹⁸ Best practice suggests the following attendees: CHW, CHW field supervisor, key members of the primary care team, including the primary care provider

¹⁹ The intention of this report is to provide the team with an update, but also to alert the team to any key areas of concern that the broader team might be able to address

- c. The network modifies its process for exchanging health information across care settings to accommodate the role and functions of the CHW support²⁰
- d. The network develops a process and protocols for connecting individuals to needed community services (i.e. social support services)

7. Identify process to determine when an individual is ready to transition to self-directed maintenance

The network develops criteria to evaluate when the individual has acquired the necessary education and self-care management skills to transition to self-directed maintenance that includes:

- i. Collaborating with the individual to assess their readiness to independently self-manage their care
- ii. Assessing improvement on the relevant clinical outcomes
- iii. Assessing achievement of individual identified care goals

²⁰ The network should have agreements with necessary care providers about exchanging information; establish the type of information to be shared (consider needs assessment self-care management plan and patient progress notes ;timeframes for exchanging information; and, how the organization facilitates referrals

CORE STANDARD 3: BEHAVIORAL HEALTH INTEGRATION

FOCUS POPULATION: PATIENTS WITH UNIDENTIFIED BEHAVIORAL HEALTH NEEDS

Program Description and Objective:

Description: The behavioral health integration standards will incorporate standardized, best-practice processes to identify unidentified behavioral health needs in the primary care setting. This program seeks to bolster the ability of providers to perform these functions while optimizing existing resources.

Coordinating care for those with identified chronic behavioral health needs is critical and expected of networks. CCIP standards focus on unidentified behavioral health needs and primary care coordinated interventions in order to avoid duplication with existing programs for higher risk individuals (e.g., the Department of Mental Health and Addiction Service’s Behavioral Health Homes).

Objective: To improve the ability of healthcare providers to identify and treat behavioral health needs and to improve the overall state of behavioral health in Connecticut.

High-Level Intervention Design:

- 1. Identify individuals with behavioral health needs**
- 2. Address behavioral health needs**
- 3. Behavioral health communication with primary care source of referral**
- 4. Track behavioral health outcomes/improvement for identified individuals**

1. Identify individuals with behavioral health needs²¹

- a. The network uses a screening tool for behavioral health needs that is comprehensive and designed to identify a broad range of behavioral health needs at a minimum including:
 - i. Depression
 - ii. Anxiety
 - iii. Substance abuse
 - iv. Trauma
- b. The network develops a screening tool that can be self-administered or administered by an individual who does not have a mental health degree²² that includes:
 - i. The PHQ-9 to screen for depression
 - ii. Standardized and validated screening tools for behavioral health needs outside of depression
- c. The network ensures there are support services to administer the tool for individuals with barriers to filling out the screening tool on their own²³

²¹ The screening is not intended to identify individuals with severe and persistent mental illness

²² The tool does not have to screen for a diagnosis but screen for areas of concern for follow-up by a licensed behavioral health specialist, and the individual who administers the tool should be trained to flag when follow-up screening of additional needs is required by a licensed clinician. Patients aged 12 and older, when possible, should complete the screening tool without the support of their parents.

²³ The networks should encourage patients aged 12 or older, when possible, to complete the screening tool without the support of their parents.

- d. The network utilizes a trained behavioral health specialist on site or through referral (at least with masters level training) who is expected to do a more targeted follow-up assessment²⁴ with the individual when necessary
- e. The network conducts the behavioral health screening no less often than every two years
- f. The network develops a process for identifying a re-screening at each routine visit²⁵
- g. The screening tool results are captured in the EMR and made accessible to all relevant care team members

2. Address behavioral health needs

- a. The network conducts an assessment of needed behavioral health resources to support its practices and establishes the necessary relationships with behavioral health providers to meet those needs
- b. If sufficient behavioral health services are not in network, the network executes an MOU with at least one behavioral health clinic and/or practice and develops processes and protocols for other behavioral health providers that include²⁶
- c. The network use standardized set of criteria to determine whether or not the behavioral health need can be addressed in the primary care setting by a primary care provider that considers²⁷:
 - i. The diagnosis/behavioral health need
 - ii. Severity of the need
 - iii. Comfort level of the primary care team to manage the individual's needs
 - iv. Complexity of the required medication management
 - v. Age of the individual
 - vi. Individual preference
 - vii. If the provider doing medication management for the individual has psychiatric medication management training
- d. The network has a mechanism for identifying available behavioral health resources and educates the individual on what these resources are regardless of whether or not a referral is needed.²⁸

²⁴ The assessment should reflect the needs identified by the screening tool.

²⁵ This re-screening could include questions asked about changes by doctor or nurse as part of routine visit.

²⁶ This is recommended to ensure that an individual who chooses to seek care from a provider outside of the network or with whom there is no MOU is still assisted and supported in the referral process and does not feel pressured to receive care from a limited set of providers. Additionally, behavioral health needs vary and it may not be realistic to have providers in the network or MOUs with the extent of providers that cover the breadth of behavioral health needs that may arise (e.g., addiction treatment, depression, anxiety, etc.). Processes and protocols should identify how information will be exchanged with provider for whom there is not an MOU (e.g., release of information)

²⁷ If the individual can be treated in the primary care setting, it is expected that the individual be engaged to determine where they would prefer to receive care including primary care provider in the primary care setting, a behavioral health specialist in a behavioral health setting, or behavioral health specialist in a primary care setting if possible. If the individual's needs cannot be addressed in the primary care setting, it is expected the individual be engaged to inform and educate them on the diagnosis/behavioral health need and why a referral/care from a behavioral health specialist is recommended. The individual who engages the individual should be the behavioral health trained care provider with whom the individual is most comfortable.

²⁸ These resources may include but are not limited to: community resources (e.g., support groups, wellness centers, etc.); alternative therapies (e.g., acupuncture); and health promotion services (e.g., women's consortium).

- e. The network ensures that primary care team members that provide behavioral healthcare will have behavioral health training that covers:
 - i. Behavioral health promotion, detection, diagnosis, and referral for treatment²⁹.
 - ii. Guidelines on how information will be exchanged and within what timeframe
 - iii. Designating an individual to be responsible for tracking and confirming referrals³⁰
 - iv. Developing technology, if possible, to alert the primary care practice when a referral is completed
 - v. Defining a timeframe within which a referral should be completed³¹
 - vi. Appropriate coding and billing³²

3. Behavioral health communication with primary care source of referral

The network develops process, protocol, and technology solutions identified for behavioral health provider to make the assessment and care plan available to the primary care team with appropriate consent

- i. The behavioral healthcare plan outlines treatment goals, including when follow up is required and who is responsible for follow up
- ii. The behavioral health provider is available for consultation as needed by the primary care physician (process for this should be outlined by MOU) if individual is transferred back to the primary care setting

4. Track behavioral health outcomes/improvement for identified individuals

- a. The network utilizes individual tracking tool to assess and document individual progress at one year and other intervals as determined by the provider
- b. The network develops processes and protocols for updating this tracking tool that includes³³:
 - i. Who is responsible for updating
 - ii. Defining intervals at which assessments are made
 - iii. Adjusting treatment when not effective

²⁹ The technical assistance vendor will assist the networks to find appropriate trainings that focus on health promotion, detection, diagnosis and referral for treatment. Trainings identified by the vendor should be made available to all networks via the internet.

³⁰ Consider a designated behavioral health referral coordinator

³¹ Completed means the consultation occurred and information on the consultation was shared with the primary care practice

³² Pending policy developments around same day billing for behavioral health services may alleviate the need for this to be required of the MOU

³³ Consider technological solutions for tracking outcomes such as a disease registry