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 XX, 2016

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Acronyms

ACO Accountable Care Organization
AHCT Access Health CT
AMH Advanced Medical Home
AN Advanced Network
APCD All-Payers Claims Database
ASO Administrative Services Organization
BRFSS Behavioral Risk Factor Surveillance System
CAB Consumer Advisory Board
CCIP Clinical & Community Integration Program
CDC Center for Disease Control and Prevention
CHW Community Health Worker
CMC Care Management Committee
CMMI Center for Medicare & Medicaid Innovations
CMS Centers for Medicare and Medicaid Services
CTG Community Transformation Grant
DMHAS Department of Mental Health and Addiction Services (CT)
DPH Department of Public Health (CT)
DSS Department of Social Services
EAC Equity and Access Council
EHR Electronic Health Record
FQHC Federally Qualified Health Center
HEC Health Enhancement Community
HIE Health Information Exchange
HISC Healthcare Innovation Steering Committee
HIT Health Information Technology
HPA Health Program Assistant
ICM Intensive Care Management
LC Learning Collaborative
MAPOC Medical Assistance Program Oversight Council
MQISSP Medicaid Quality Improvement and Shared Savings Program
MSSP Medicare Shared Savings Program
NCQA National Committee for Quality Assurance
NQF National Quality Forum
OSC Office of the State Comptroller
PCMH Patient Centered Medical Home
PCP Primary care provider
PIP Pre-implementation period (SIM grant)
PMO Program Management Office (SIM)
PSC Prevention Service Center
PTTF Practice Transformation Task Force
PY1-3 Performance year 1-3 (SIM grant)
QC Quality Council
RFP Request for Proposals
SIM State Innovation Model
SSP Shared Savings Program
TA Technical Assistance
VBID Value-based Insurance Design
VBP Value-based payment

Executive Summary

Care delivery and payment reforms have been well underway in Connecticut as a result of the combined efforts of Medicare, Medicaid, commercial payers, and providers, all of whom have been working to provide the tools and resources necessary to improve health care outcomes. The State Innovation Model initiative was established as a means to ensure that these reforms are informed by the diversity and expertise that exists within Connecticut's stakeholder community—consumers, consumer advocates, employers, health plans, providers, and state agencies. The SIM governance structure and advisory process promotes multi-payer alignment to so that payers and providers are pushing to achieve the same goals. We promote alignment on methods and requirements where this makes sense (e.g., quality measures, medical home, and community integration), while also promoting flexibility and innovation. Importantly, we also seek to ensure that the needs of the most vulnerable individuals who encounter barriers to healthcare are a central consideration, whether these individuals are covered by Medicaid, Medicare, or commercial insurance.

Governor Malloy applied for and received $45 million in federal funding from the Centers for Medicare and Medicaid Innovation to help SIM achieve its objectives of better health, eliminating health inequities, engaging consumers, improving healthcare outcomes and improving affordability. The success of our application depended on the leadership of Lt Governor Wyman and the full commitment and support of many of Connecticut's key state agencies involved in health care including the Departments of Social Services, Public Health, Insurance, Mental Health and Addiction Services, and Children and Families. It also depended on the support of the stakeholder community, which continues to provide essential guidance through our governance structure on all aspects of program design and implementation.

The **Community and Clinical Integration Program (CCIP)** is the most recent and among the most ambitious products of our collective commitments and stakeholder advisory process. CCIP includes care delivery standards and technical assistance to a) improve care for individuals with complex health needs, b) introduce new care processes to reduce health equity gaps, and c) improve access to and integration of behavioral health services. In each of these areas, available data suggests that there are sizable opportunities to improve care, especially by helping care teams to identify cultural, language, and social factors that are barriers to care and address these barriers through community linkages and new team members such as Community Health Workers.

The CCIP program is intended to complement the Medicaid Quality Improvement and Shared Savings Program (MQISSP) and its associated requirement elements. MQISSP builds on the great success of the Department of Social Services' PCMH program, which is the foundation for the MQISSP program design, and harmonizes with other effective DSS initiatives such as the Intensive Care Management (ICM) program, the medical and behavioral health ASOs, and the Health Home initiative all of which contribute to a record of quality improvement and cost savings.[1] The combined effect of the MQISSP required

[1]A summary of Medicaid's many care delivery (PCMH, Intensive Care Management, health homes) and payment reform (PCMH incentives, BH and OB P4P) achievements are summarized at the following links. https://www.cga.ct.gov/med/council/2016/0222/20160222ATTACH_DSS%20Presentation.pdf;

elements and the CCIP standards is to strengthen the capabilities of our increasingly accountable provider community with an emphasis on care coordination, team-based care, health equity, social determinant risks, community integration, community health worker supports, behavioral health integration, and the care of special populations.

Reform Strategy

A core strategy of the SIM initiative is to promote the transformation of care delivery services. Historical models of care delivery in Connecticut can be fragmented and difficult to navigate. The envisioned transformation will ensure that the patient – and, where applicable, family and caregivers – are the center of healthcare delivery processes and systems. This is known as person-centeredness. Person-centered healthcare engages patients as partners in their healthcare and relies on teams of healthcare and other workers to address the range of medical and socio-economic factors that influence good health.

Transforming care to be truly person-centered is a process that takes place at multiple levels. The medical home approach to primary care constitutes an essential building block for a person-centered healthcare system. Medical homes utilize a team-based approach to deliver comprehensive, coordinated, accessible primary care and preventive services to patients. To encourage medical homes, the SIM initiative in Connecticut developed the Advanced Medical Home (AMH) Program to help practices create the infrastructure required for transformation.

In addition to transforming care at the practice level, SIM seeks to transform care at the "network" level. Many of the services and resources that need to be incorporated in a truly person-centered healthcare delivery system lie outside of the individual primary care office. Some of these services exist or could be built into large networks of primary care practices, which sometimes include healthcare facilities and other providers. Provider networks that are organizing to take financial responsibility for clinical quality, total cost of care, and patient health outcomes are well-positioned to adopt this broader approach to health services. We refer to these organizations as "**Advanced Networks**." SIM seeks to support the development of the processes to support patient needs at the network level through the launch of the CCIP, which is the focus of this report. CCIP will support these networks in the development of new capabilities to effectively integrate non-clinical community services with traditional clinical care into a set of comprehensive, person-centered primary care services that support patient goals. The AMH program complements CCIP by working with individual practices within Advanced Networks to help them become medical homes.

Planning Process and Program Design

The SIM Program Management Office (PMO) convened the Practice Transformation Task Force (PTTF) to provide advice to the Healthcare Innovation Steering Committee on the design of SIM-funded programs that promote more person-centered care delivery in Connecticut's Advanced Networks. The PTTF first

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https://www.cga.ct.gov/med/council/2015/1211/20151211ATTACH_NGA%20high%20cost%20high%20need%20-%20FINAL.pdf

developed standards for the AMH program and then developed standards for the CCIP program that are covered in this report.

The PTTF embarked on the development of the CCIP standards through a systematic process that included: (1) understanding what capabilities Advanced Networks have deployed in Connecticut and across the country to enable transformation; (2) reviewing the evidence base that support each capability; (3) assessing the areas of greatest need in Connecticut from a population and provider perspective; and (4) building practice standards that will enable Advanced Networks to better address those needs.

The PTTF sought to identify populations with distinct, demonstrated needs, given the results of a literature review suggesting that programs focused on distinct populations generally yield better results. To identify the focus populations of CCIP, the PTTF followed three design criteria: (1) alignment with stated SIM goals, (2) alignment with the population health needs of Connecticut, and (3) strong evidence base that could lead to standardized care processes. Based on these criteria, the PTTF identified three groups of Connecticut residents for the core CCIP standards:

Patients 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.

Patients Experiencing Equity Gaps: Individuals belonging to a sub-population experiencing poorer health outcomes in a specific clinical area (e.g., diabetes).

Patients with Unidentified Behavioral Health Needs: Any individual with a previously unidentified behavioral health need including mental health, substance abuse, or history of trauma.

Each of these populations has a demonstrated health need in Connecticut with significant room for improvement. These populations tend to also have significant socio-economic determinants of health and would benefit from the better integration of medical and non-clinical community services.

The PTTF sought to design standards for each of these populations that orient the primary care team around patient preferences, needs, and values and integrate the primary care team with additional supports and services. These are known as **"core standards."** They represent capabilities that we will aim to develop among all CCIP participating entities with the goal of promoting more person-centered care for the populations of focus described above:

Comprehensive Care Management

The standards for individuals with complex health needs are intended to complement existing care coordination and medical home capabilities that exist in many of Connecticut's Advanced Networks. The standards will enable medical homes to more effectively identify individuals who would benefit from comprehensive care management, engage those individuals in self-care management, and coordinate services by means of comprehensive care team that includes community-based service and support providers. Some participating networks will be able to meet the standards in part or whole through existing programs; others may need to develop additional capabilities.

Health Equity Improvement

The health equity standards are comprised of two parts: Part 1 focuses on the development of standardized processes for Advanced Networks to use data to identify and address healthcare disparities. Part 2 pairs these general capabilities with a condition specific health equity pilot intervention that focuses on: (a) Reducing health equity gaps by tailoring elements of the care processes to be more culturally and linguistically appropriate; and (b) Developing processes in the primary care practice to identify individuals experiencing gaps in their health outcomes who would benefit from more culturally attuned care interventions and connect them to those interventions. This will require the re-engineering of care processes to optimize performance and minimize sub-population specific barriers in the care pathway. The culturally specific intervention will include: (1) Use of a community health worker who has culturally and linguistically sensitive training to educate individuals about their condition and empower them to better manage their own care; and (2) Producing translated and culturally appropriate educational materials. The primary purpose of the pilot is to develop the network's skills with a specific sub-population and condition so that these same skills can then be applied to other sub-populations and conditions.

Behavioral Health Integration

The behavioral health integration standards will incorporate standardized, best-practice processes to identify behavioral health needs in the primary care setting, address those needs in primary care or via referral, coordination with behavioral health specialist, and outcome tracking. This program seeks to bolster the ability of Advanced Networks to perform these functions as well as optimize existing resources.

Each standard is comprised of elements and sub-elements that detail the expectations associated with the target capabilities. The elements that comprise each of the core standards is provided in the table below and further detailed in Appendix A:

Core Standard 1	Comprehensive Care Management
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

Core Standard 2	Health Equity Improvement
Part 1	
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
Part 2	
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
Core Standard 3	**Behavioral Health Integration**
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

The PTTF also defined **"elective standards"** to complement the core standards. These elective standards provide an evidence-based framework for Advanced Networks that choose to pursue these capabilities to better meet the individual needs of patients. They include the following:

- **E-consults:** The e-consults standards address the lack of access to specialty providers by establishing protocols for primary care providers to consult with specialists. This model has been shown to decrease costs, increase access, and enhance primary care provider capabilities.
- **Comprehensive Medication Management (CMM):** The CMM standards provide a framework for providers to engage patients with complex medication regimens to increase adherence and reduce complications.
- **Oral Health:** The oral health standards are designed to increase oral health access and capabilities within the primary care setting to improve both oral and overall health.

The elements that comprise the elective standards are provided in the table below and more fully detailed in Appendix B.

Elective Standard 1	**Oral Health Integration**
1	Screen individuals for oral health risk factors and symptoms of oral disease
2	Determine best course of treatment for individual
3	Provide necessary treatment–within primary care setting or referral to oral health provider
4	Track oral health outcomes/improvement for decision support and population health management
Elective Standard 2	**Electronic Consultation (E-Consult)**
1	Identify individuals eligible for e-consult
2	Primary care provider places e-consult to specialist provider
3	Specialist determines if in person consult is needed or if additional information is needed to determine the need for in person consult
4	Specialist communicates outcome back to primary care provider
Elective Standard 3	**Comprehensive Medication Management**
1	Identify patients requiring comprehensive medication management
2	Pharmacist consults with patient/caregiver in coordination with PCP or comprehensive care team
3	Develop and implement a person-centered medication action plan
4	Follow-up and monitor the effectiveness of the medication action plan for the identified patient

Program Implementation

The CCIP implementation process will be overseen by the PMO. The PMO will contract with one or more transformation vendors that will provide technical assistance to participating Advanced Networks to help them meet the standards. The transformation vendor(s) will also be responsible for convening local **Community Health Collaboratives**. A survey of the existing health and healthcare related collaborative structures will be undertaken so that, where appropriate, our approach can mobilize existing partnerships and resources. The Collaboratives will be tasked with establishing community-wide processes for the coordination, communication, and integration of clinical services with community services and supports. Protocols that support safe and effective care transitions between entities that

are not part of the same network will also be an important area of focus for this initiative. More information on the Community Health Collaboratives can be found in Appendix C.

The Department of Social Services (DSS) will embed requirements related to CCIP standards within the Request for Proposals (RFP) through which DSS will procure Participating Entities for the Medicaid Quality Improvement & Shared Savings Program (MQISSP). For purposes of the first wave of MQISSP, DSS and the PMO have agreed to permit applicants to choose whether or not they will be bound by the CCIP standards. The DSS MQISSP RFP will offer two tracks, from which applicants must choose. The first track will require participating entities to participate in CCIP technical assistance, but will not require demonstrated achievement of the CCIP standards as a condition for continued participation in MQISSP. The other will enable Participating Entities to indicate that they agree to be bound by CCIP standards and will give them the option to apply for proposed transformation awards. For the second wave MQISSP procurement, achievement of the CCIP standards, as revised, will be a condition for all MQISSP Participating Entities, including those entities that were exempt during the first wave.

The PMO will provide tailored technical assistance to help participating entities develop the capabilities to meet the core standards and for building the infrastructure to provide person-centered care that integrates the range of medical and social services needed for person-centered care delivery. Participating Advanced Networks that choose to implement CCIP's elective standards will be eligible for the same technical assistance for the elective services as for the core. Although the CCIP standards are focused on improving care for all populations, the PMO will, through the support provided to participating entities, endeavor to keep the best interests of Medicaid beneficiaries at the forefront as they work toward achievement of these capabilities. Only Advanced Networks and FQHCs that are participating in MQISSP will be eligible for this transformation support. The PMO intends to seek authorization from CMMI to offer competitive awards to support the transformation process.

Taken together, the CCIP program standards represent a model that begins the process of integrating clinical and non-clinical services into a system-wide approach to person-centered care delivery for Connecticut's Advanced Networks. In recommending these standards, the PTTF sought to balance the value of having consistent standards with the need for organizations to have the flexibility to innovate and adapt the models to better support the populations they serve and consider the strengths and needs of the communities where they reside. Within each core and elective capability, standards include both required actions and recommended actions. It is the hope of the PTTF that this model will provide Advanced Networks and FQHCs with tools to deliver comprehensive, person-centered care to their entire patient population.

1. Introduction

The State Innovation Model (SIM) program is a Centers of Medicare & Medicaid Innovation (CMMI) initiative to support the development and implementation of multi-payer healthcare payment and service delivery model reforms that will improve health system performance, increase quality of care, and decrease costs in participating states. As part of this program, Connecticut released its State Healthcare Innovation Plan (SHIP) articulating a vision to transform healthcare by establishing a whole-person-centered healthcare system that improves community health and eliminates health inequities; ensures superior access, quality, and care experience; empowers individuals to actively participate in their health and healthcare; and improves affordability by reducing health care costs. In 2014 Connecticut received a $45 million State Innovation Model (SIM) grant from the Centers of Medicare & Medicaid Innovation (CMMI) to implement its plan for achieving this vision over a four year period (2015-2019).

SIM Care Delivery Transformation Initiatives

Connecticut's SIM initiative recognizes the importance of investing in care delivery transformation that promotes person-centered care, improves care coordination, builds community linkages, and reduces health disparities. In order to understand SIM's transformation strategy, it is important to understand the challenges that patients and providers face today, and how many providers in Connecticut are currently organizing to improve on historical approaches to care delivery.

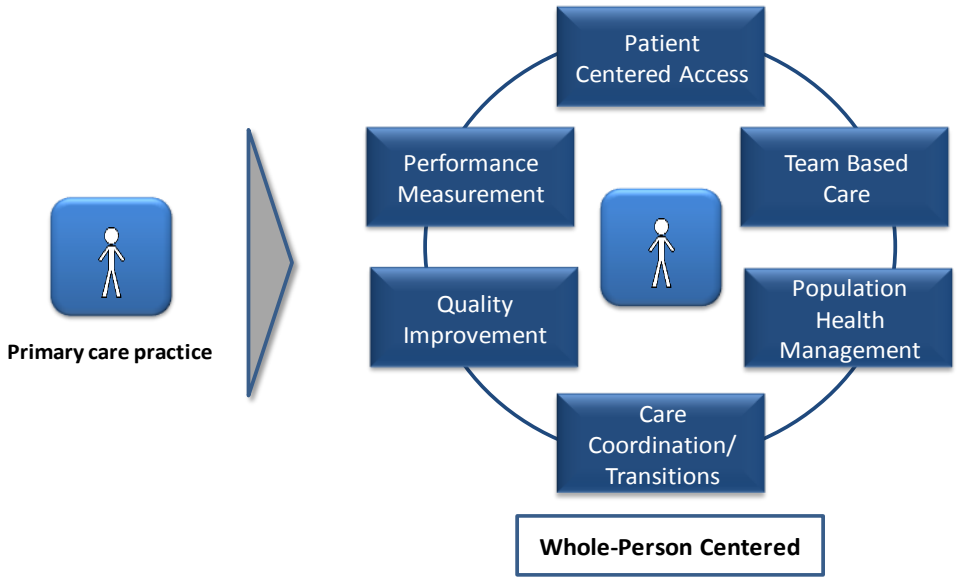
Historically, patients have experienced care that frequently is uncoordinated, that does not effectively empower patients as participants in their own healthcare, and that may not address root causes of health conditions. Care delivery transformation is designed to address these historical limitations, and to capitalize on the opportunity that exists to involve patients in improving their own health by placing their strengths and needs at the center of the care model.

One of the principal areas in which care transformation activities have focused to date is primary care. In many ways, primary care is the foundation of our healthcare delivery system. It is the point through which most patients initially access healthcare services, and the breadth of its scope allows it serve as a natural starting point from which to design more person-centered care models. Many primary care practices are working to improve the quality of their care by adopting a model of care known as the patient-centered medical home (PCMH). Medical homes aim to provide holistic, accessible care by employing integrated care teams, using evidence-based guidelines, and building relationships with patients to understand their needs, wishes, and barriers to care.

CT SIM developed the **Advanced Medical Home Program** as a way to help practices create the infrastructure that is required to become a medical home, and to augment traditional medical home standards in a way that places an emphasis on capabilities that are important to achieving Connecticut's care transformation goals.

Advanced Medical Home Program

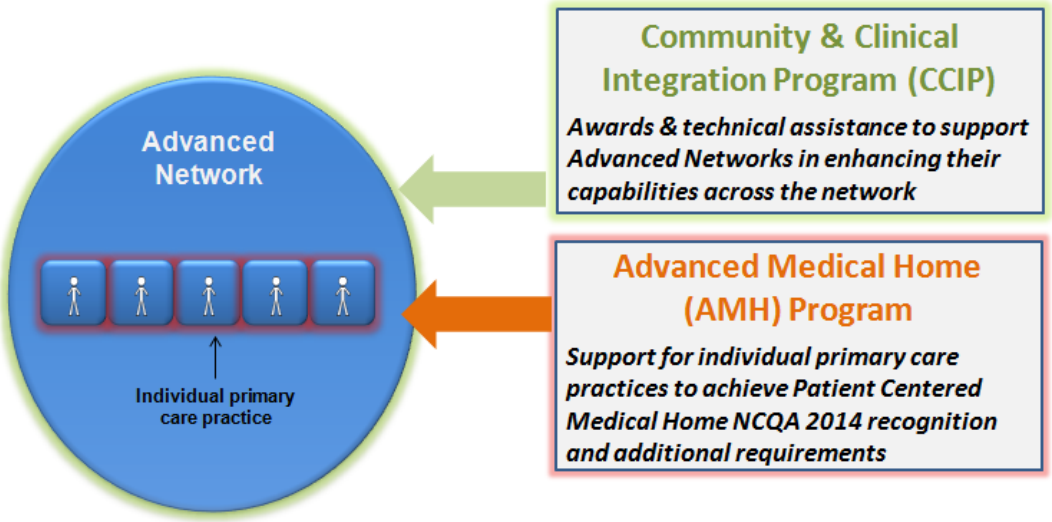
Webinars, peer learning & on-site support for individual primary care practices to achieve Patient Centered Medical Home NCQA 2014 accreditation as well as additional required criteria.



Most primary care practices belong to a larger network of providers that are organizing to take responsibility for providing higher-quality care at a lower cost. These organizations, which we refer to as **Advanced Networks**[2] or simply "networks," are entering into value-based payment arrangements with Medicare and commercial health plans in order to incent and finance the evolution of their business models. This evolution involves investing in new technologies, new staff (e.g., care coordinators), and new care processes. The AMH program is designed to help Advanced Networks succeed in these new payment models by helping their practices become medical homes, if they have not done so already.

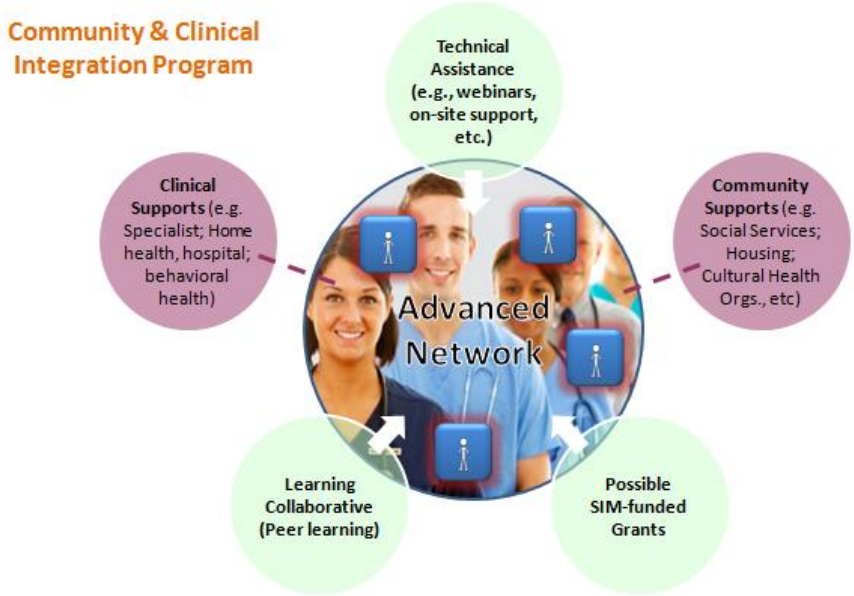
One of the greatest challenges that Advanced Networks face is integrating their work effectively with that of organizations outside their network that provide key healthcare and non-clinical support services. As part of Connecticut's effort to promote care delivery transformation, SIM will fund the launch of the **Clinical and Community Integration Program (CCIP)**, which aims to help Advanced Networks respond effectively to these and other challenges. In contrast to the AMH program which focuses on individual practices, the CCIP program engages the organization and its entire network of practices with the goal of developing new processes to support patient needs. Engaging the organization and its leadership is the best way to introduce changes that require investments in the infrastructure (e.g., electronic health records or EHR) or changes to care processes that are standardized across the network of affiliated practices. Thus, the SIM-funded AMH program and CCIP are complementary initiatives designed to help these organizations realize their goals of better patient care at a lower cost.

[2]Federally Qualified Health Centers (FQHCs) are also major providers of primary care in Connecticut that face challenges similar to Advanced Networks. Connecticut's FQHCs have made a strong commitment to provide high-quality, cost-efficient care and developing the new capabilities needed to succeed under new payment models.



Community and Clinical Integration Program (CCIP)

One of CCIP's primary aims is to more effectively integrate **non-clinical community services** and traditional clinical care into a set of comprehensive, routine primary care services. The need within Connecticut – and nationwide – for better integration of community and clinical services is well recognized; research has shown that 60% of a patient's overall health status is influenced by social determinants, behavioral choices, and environmental conditions, most of which lie outside the reach of our healthcare providers. In comparison, 10% of health is influenced by medical care and 30% by genetics (McGinnis JM, 2002). This suggests that a patient with healthy behavior (e.g. frequent exercise, balanced diet, and sufficient sleep), favorable socio-economic circumstances, good living conditions, and access to routine preventive care has a better chance of experiencing positive health outcomes. Achieving Connecticut's healthcare goals will require identifying and addressing the non-clinical needs that contribute to poor health outcomes. A special emphasis will be placed on partnering with community organizations that work to lessen environmental risks such as housing instability or unemployment. This approach will make it possible to improve care for patients with complex care needs, reduce health equity gaps, and improve the overall care experience. As part of CCIP, SIM will provide a variety of



supports to Advanced Networks including technical assistance, learning collaboratives, and possible SIM-funded transformation grants.

Which Providers Will Participate in CCIP?

The CCIP standards are intended to support the advancement of Advanced Networks and Federally Qualified Health Centers (FQHCs)[3] that are selected to participate in the Connecticut Medicaid Quality Improvement and Shared Savings Program (MQISSP). For purposes of the first wave of MQISSP, DSS and the PMO have agreed to permit applicants to choose whether or not they will be bound by the CCIP standards. The DSS MQISSP RFP will offer two tracks, from which applicants must choose. The first track will require participating entities to participate in CCIP technical assistance, but will not require demonstrated achievement of the CCIP standards as a condition for continued participation in MQISSP. The other will enable Participating Entities to indicate that they agree to be bound by CCIP standards and will give them the option to apply for proposed transformation awards. For the second wave MQISSP procurement, achievement of the CCIP standards, as revised, will be a condition for all MQISSP Participating Entities, including those entities that were exempt during the first wave. Participants in the CMMI funded Practice Transformation Network (PTN) initiative are exempt from this requirement. DSS will require participating entities to work towards CCIP standards in addition to MQISSP required elements related to care coordination, integration of behavioral health, the care of special populations, and cultural and linguistic appropriateness standards.

Although participation in MQISSP is an eligibility requirement, the administration of CCIP will focus on improving care for all patients regardless of their insurance carrier (i.e. payer)—supporting the best interests of individuals insured by Medicaid, commercial plans, or Medicare. This all-payer focus notwithstanding, the PMO will, through the support provided by its technical assistance vendor, strive to keep the best interests of Medicaid beneficiaries at the forefront as participating entities work towards achieving the standards.

MQISSP and CCIP align with the payment and care delivery reforms that more and more Advanced Networks have encountered by virtue of their participation in value-based contracts with Medicare and commercial payers. Together, this set of incentives and new capabilities will enable Advanced Networks to improve the overall efficiency and effectiveness of patient care for all of the populations for which they are responsible.

[3] Throughout this report, the term Advanced Networks or “networks” will be used to refer to Advanced Networks as well as FQHCs that qualify for participation in CCIP.

2. Connecticut SIM Governance Structure & PTTF

Connecticut's SIM initiative is composed of a number of initiatives that include plans to improve population health, promote value-based payment and insurance designs, encourage quality measure alignment, update health information technology, implement a Medicaid Quality Improvement and Shared Savings Program, and transform primary care.

Definitions:

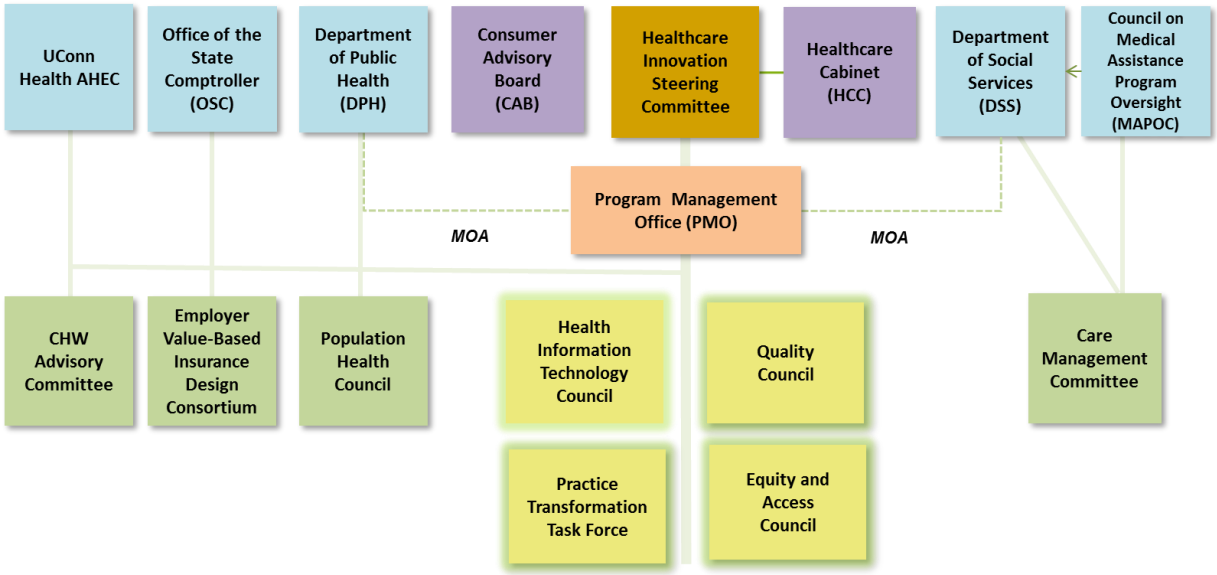
Person-Centered: Person-centered care engages patients as partners in their healthcare and focuses on the individual's choices, strengths, values, beliefs, preferences, and needs to ensure that these factors guide all clinical decisions as well as non-clinical decisions that support independence, self-determination, recovery, and wellness (quality of life). The individual engages in a process of shared-decision making to make informed decisions about their care plan and treatment. The individual identifies their natural supports, which may include but is not limited to family, clergy, friends and neighbors and chooses whether to involve them in their medical care planning.

Value-Based Payment: Form of payment that holds provider organizations accountable for the cost and quality of care they provide to patients. This differs from the more traditional fee for service payment method in which providers are paid for volume of visits and services. The goal of value-based payments is to reduce inappropriate care and reward providers and supporting organizations for delivering value to patients. A shared savings programs (SSP) is a type of value-based payment model.

Shared Savings Program: A form of a value-based payment that offers incentives to provider organizations to reduce healthcare spending and improve quality for a defined patient population. Provider organizations earn a percentage of the net savings realized as a result of their efforts. Savings are typically calculated as the difference between actual and expected expenditures to care for a given patient population. Savings are shared between payers and providers.

Oversight of Connecticut's SIM initiative is provided by the Healthcare Innovation Steering Committee, chaired by Lieutenant Governor Nancy Wyman. The design and implementation of the SIM component initiatives is informed by a number of advisory groups that are supported by the SIM Program Management Office (PMO) or by partner state agencies. The work group responsible for generating the recommendations included in this report is the Practice Transformation Taskforce (PTTF).

SIM Governance Structure



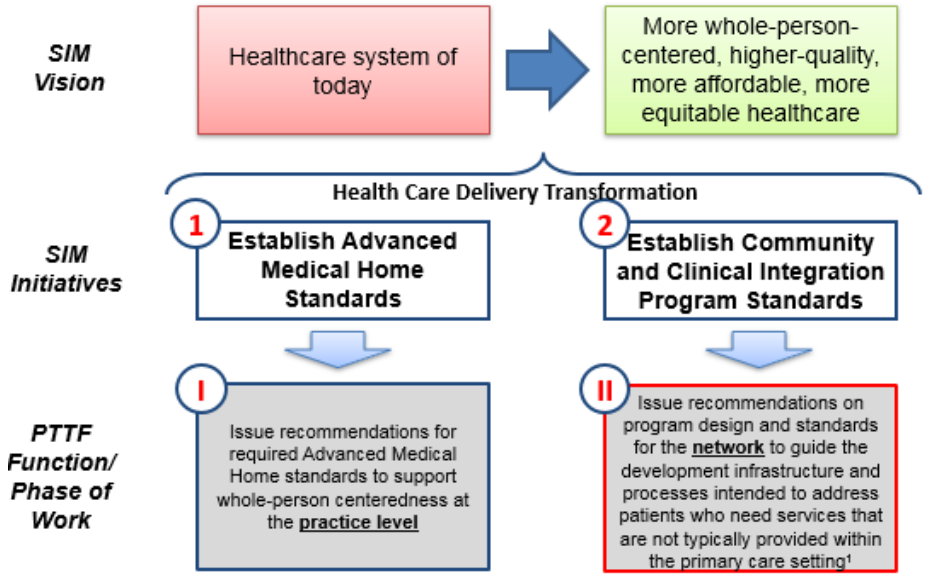
The PTTF is responsible for providing advice to the Healthcare Innovation Steering Committee on the design of SIM-funded programs that enable care delivery transformation consistent with the SIM vision. To accomplish its work, the PTTF split the work into two phases. In the first phase of work the PTTF was charged with developing AMH standards. In the second phase of work the PTTF was tasked with developing CCIP standards for Advanced Networks and FQHCs.

The Task Force is comprised of a wide range of consumers and consumer advocates, physicians, a provider of behavioral health services, experts in community services and care management, a Federally Qualified Health Center, an APRN, health plans, and state agencies. Consumer representatives include individuals who have experience relying on the health system for their own significant medical needs or those of a family member. Consumer advocates included individuals with expertise in school-based health, oral health, and community support services. State agency representatives included the Connecticut Medicaid Director and staff of the Department of Mental Health and Addiction Services. Prior to beginning the design of CCIP, the Task Force membership was supplemented by a specialist in care management, a cultural health organization representative with community health worker experience, a specialist in home health and related services, a practice manager for an Advanced Network, and a psychologist with expertise in housing and homelessness. The Medical Assistance Program Oversight Council (MAPOC) appointed two of the Task Force members. The Task Force established design groups as needed to provide additional representation and expert consultation in the areas of health equity, behavioral health, and oral health.

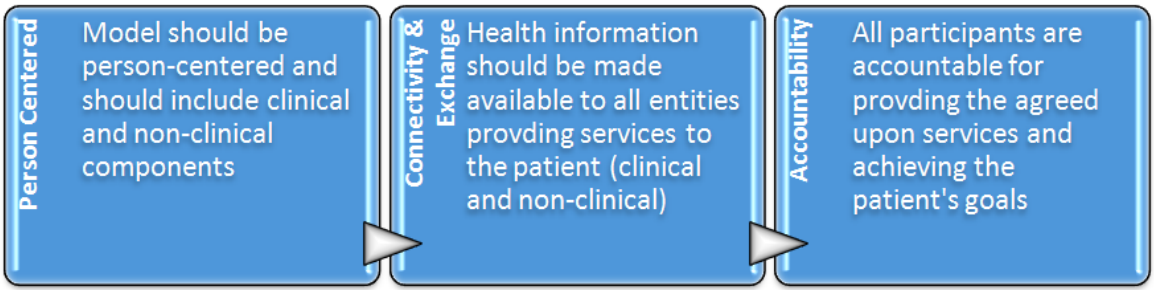
Refer to Appendix E for Task Force Member Listing.

Guiding Principles

One important focus of the CCIP is to improve outcomes for individuals with significant non-clinical needs. This will require a careful "person-centered" assessment and care plan combined with better integration of clinical (e.g., behavioral and oral health) and non-clinical services (e.g., housing, employment assistance) with high-quality routine primary care, and better care management. To assist with the design of a model that suits Connecticut's needs, the PTTF analyzed effective models in other parts of the country and developed **three guiding principles** to inform the Task Force's work.



Guiding Principles



3. Approach to Design

A thorough planning process was undertaken in the design of the CCIP standards. The Practice Transformation Task Force (PTTF or "Task Force") and its design groups held more than 25 meetings to providing advice and recommendations regarding CCIP. The standards chosen were based on capabilities that aim to address these gaps and improve health care quality and health outcomes, and reduce costs.

Design Strategy

With the Guiding Principles and the SIM goals in mind, the PTTF began its work by establishing three objectives: (1) Gain a better understanding of the eleven capabilities set forth in the SIM grant application and their relative effectiveness; (2) Understand how local and national programs were

addressing similar objectives; and (3) Evaluate how these capabilities could best align with the needs of the residents of Connecticut.

The Connecticut SIM grant identified **eleven capabilities** that Advanced Networks could develop to support greater community and clinical integration. These capabilities represent actions that further one or more of the practice transformation goals of SIM:

1) Integrating behavioral health into primary care
2) Integrating oral health into primary care
3) Providing comprehensive medication management services
4) Building dynamic clinical teams (note: this is later referred to as a "comprehensive care team")
5) Expanding e-consults between primary care providers and specialists
6) Incorporating community health workers as health coaches and patient navigators
7) Closing health equity gaps (through the ability to identify the gap using clinical data)
8) Improving the care experience for vulnerable populations (using care experience data)
9) Establishing community linkages with providers of social services, long term support services (LTSS), and preventive health
10) Identifying patients with complex health needs
11) Producing actionable quality improvement reports

To gain a better understanding of the capabilities and their effectiveness, how they were being applied across the country, and how they supported Connecticut's needs, the Task Force:

- Reviewed literature on the effectiveness of these capabilities
- Solicited Center for Medicaid and Medicare Innovation (CMMI) technical assistance[4]
- Conducted interviews with subject matter experts and leadership teams running programs across the country that were intended to achieve similar objectives
- Received input from Connecticut Stakeholders

Reviews covered local and national transformation efforts, including work being done in Hennepin County, through existing Community Care Teams, the Camden Coalition on hot spotting, and many others. As part of the landscape review, interviews were also conducted with Kate McEvoy, Medicaid Director and Dawn Lambert of the Department of Social Services with a focus on Long Term Support Services, Money Follows the Person, and the Dual Eligible/Healthy Neighborhoods initiative. In addition to learning from the approaches used in these innovative programs, the Task Force developed an understanding of their specialized nature and the unique needs of the populations they serve. Adjustments were made to the Comprehensive Care Management conceptual model and corresponding standards to minimize overlap. Kate McEvoy also conducted a special webinar presentation for PTTF members, which included discussion of an array of successful care delivery and/or payment reform initiatives such as the PCMH program, the Intensive Care Management Program, and the Health Home initiative.

[4] CMMI technical assistance is provided to all states participating in SIM to support grant implementation activities. The information provided often draws on best practices from other states participating in SIM.

In its evaluation of the individual capabilities, the PTTF concluded that **each capability is an important element in supporting the objectives of CCIP.** Table 1 summarizes the some of the positive outcomes outlined in the evidence base that resulted from the implementation of the corresponding capabilities outlined above.

Table 1

#	Capability	Summary of Effectiveness
1	Integrating Behavioral Health with Primary Care	• Reduction in overall medical care utilization and cost through better behavioral health integration into primary care that identified patient needs earlier and addressed them appropriately (Community Health Network of Washington, 2013)
2	Integrating Oral Health with Primary Care	• Better treatment of periodontal disease can lead to improved outcomes and lower costs related to other healthcare conditions (Qualis Health, 2015)
3	Comprehensive Medication Management	• Reduced medication and other healthcare utilization cost/claim and annual cost/patient; Improved patient satisfaction (Smith M, 2013)
4	Comprehensive Care Team*	• Increased primary care provider visits and reduced emergency department visits and inpatient admissions (Health, 2014)
5	Electronic Consults	• Timely access to medical care and reduced patient wait times for specialist appointments (UCONN Health; Center for Public Health and Health Policy, 2014)
6	Community Health Workers	• Improved quality, healthy equity and costs (The Institute for Clinical and Economic Review, 2013)
7	Closing Equity Gaps	• Allows for design of equity gap interventions tailored to meet needs of patients experiencing the disparity
8	Identifying Care Experience Opportunities	• Early program results for patients with high needs are showing improved patient experience (Health, 2014)
9	Community Linkages	• Crucial component of addressing complex patients and equity gaps (The Center for Health Care Strategies, Inc., 2014)
10	Identifying High Needs Patients	• A number of innovative models across the country are currently being tested and while still early, some initially are showing positive outcomes – improved quality and lower cost (Health, 2014) (DiPietro, 2015)
11	Actionable Quality Improvement Reports	• Providing quality information can help pinpoint where improvements are needed (Halfon N, 2014)

* The term "dynamic clinical care team" was changed to **comprehensive care team** to more accurately describe the purpose of the team as reflected in the literature.

While each of the eleven capabilities could contribute to more comprehensive, person-centered care for Connecticut residents, their effective deployment as an integrated program depends on how the capabilities relate to one another and how they benefit specific populations they are intended to support. The PTTF therefore sought to define a set of capabilities that organize these eleven actions into a smaller number of integrated core and elective standard sets.

With this framework, the PTTF organized the balance of the **design process** to accomplish the following:

1. Identify the populations to be the focus of the standards;

2. Define which capabilities are core to addressing the needs of these focus populations and which are elective;
3. Design corresponding evidence-based standards that can be flexibility applied based on the characteristics of the populations and communities they serve.

After the PTTF determined the focus populations and the associated core and elective capabilities, the Task Force split into smaller **design groups** to aggregate the expertise of members around particular model components. The design groups addressed the detailed design elements of the capabilities to address the needs of each focus population (high level program design and standards) as follows:

Design Group 1	Design Group 2	Design Group 3
Focused on developing guidelines for the clinical capabilities	Focused on developing standards for linkages formed outside the network – this includes developing a governance structure that promotes accountability amongst partners for 1) providing agreed upon services and, 2) improving patient outcomes	Focused on developing guidelines around the analytic methods for identifying target populations, technology to support seamless communication between care team members and community partners, and defining how to measure and report on program performance

The design groups reviewed program design options and standards in more detail. These groups then summarized their discussions and conveyed their points of view to the full PTTF for further analysis to finalize the recommendations for each focus population. PTTF members participated in different design groups based on their backgrounds, expertise, and interests and were asked to participate in two design sessions throughout the process. Design group meetings were open to all PTTF members and to the public.

Coordination with the Care Management Committee of the Medical Assistance Program Oversight Council [5]

DSS and the SIM PMO recognize the importance of providing for input from the Care Management Committee as it relates to the development of CCIP standards. The PMO made considerable efforts to provide for this input including a presentation to the Care Management Committee in September 2015,

[5]The Medical Assistance Program Oversight Council advises the Commissioner of Social Services on, "the planning and implementation of the health care delivery system for the following health care programs: The HUSKY Plan, Parts A and B and the Medicaid program, including, but not limited to, the portions of the program serving low income adults, the aged, blind and disabled individuals, individuals who are dually eligible for Medicaid and Medicare and individuals with preexisting medical conditions. The council shall monitor planning and implementation of matters related to Medicaid care management initiatives including, but not limited to, (1) eligibility standards, (2) benefits, (3) access, (4) quality assurance, (5) outcome measures, and (6) the issuance of any request for proposal by the Department of Social Services for utilization of an administrative services organization in connection with such initiatives (C.G.S. 17b-28).

publishing or otherwise making available draft reports beginning in September, webinars in September and November 2015, and several meetings in February 2016 including a joint meeting with the Practice Transformation Task Force, a meeting with the full Care Management Committee, and a meeting with the Care Management Committee work group. In addition, the PMO held two open comment periods: one in September-October 2015 and one which ended March 2, 2016.

A number of comments were received in our most recent comment period, including letters signed by several members of the Care Management Committee. All public comments from this second round, including expressions of support and concern by members of the Care Management Committee and other stakeholders, are published at the following link:

Compendium of Public Comments

The PMO worked closely with DSS to revise the implementation strategy to address many of the concerns that were raised by the Care Management Committee members. These revisions include the introduction of a two-track approach for entities participating in the first wave of MQISSP and other accommodations and requirements that apply to entities that participate in the first wave. The response to concerns that was prepared by the PMO and DSS included the modified implementation strategy and other accommodations. A list of the responses and the areas where they are addressed in this document is provided in the table below:

Concern	Response
○ It is not clear on what basis the CCIP standards were selected. What is the evidence basis for these standards?	See pages 17-20 and 22-32 in addition to the citations included in Appendices F & G
○ Who are the members of the Practice Transformation Task Force?	See Appendix E
○ The CCIP standards appear only to be mandatory for Medicaid participating providers. The PTTF should consider requiring all private payers to commit to requiring non-Medicaid participating providers to fulfill the CCIP standards.	See page 45, “Applicability to All Providers and All Populations”
○ CCIP standards are inflexible, overly detailed and in some cases vague. CCIP standards fail to accommodate existing local coordination efforts and to recognize the value of local innovation.	See page 32, “Customized Technical Assistance,” page 34, “Specificity and Flexibility,” and page 37, “Coordination with other DSS and Community Initiatives”
○ Meeting CCIP standards will be costly for providers, and there is no identified funding source for providers. How does the program take this into account and what types of support is provided?	See page 42, “Costs Associated with Meeting the CCIP Standards”

○ It is not clear how and by whom the CCIP standards will be enforced.	See page 44, "Enforcement"
○ How does CCIP harmonize with the 1) existing Medicaid Intensive Care Management Program and PCMH coordination efforts; and 2) other cross-department and cross-sector initiatives e.g., around children's mental health?	See page 37, "Coordination with other DSS and Community Initiatives"
○ The CCIP report specifically references intent to harmonize with Medicare initiatives, but makes no mention of any obligation to support the best interests of Medicaid members.	See page 36 and also page 45, "Promoting the Best Interests of Medicaid Beneficiaries"

Members of the Care Management Committee asked why the Care Management Committee is not the main advisory body for CCIP. The Care Management Committee's relationship to CCIP is analogous to its relationship to the NCQA PCMH program. The Care Management Committee is the main advisory body with respect to DSS's PCMH program, which requires adherence to NCQA's standards for PCMH. However, the Care Management Committee is not an advisory body for NCQA or its PCMH program. Nonetheless, the SIM Program Management Office and the Task Force have been interested in obtaining input from the Care Management Committee with respect to CCIP standards and began the process of soliciting their input in September 2015.

In February some members also noted that there was insufficient time remaining before the MQISSP Request for Proposals (RFP) must be finalized for members of the Care Management Committee to properly consider the CCIP standards. The Department of Social Services and the SIM PMO recognized that some members of the Care Management Committee felt that there was insufficient time to resolve their concerns for the Wave 1 procurement. The Department of Social Services and the SIM PMO carefully considered the recommendations to make the CCIP core standards voluntary or to delay the date on which the CCIP standards attach to participating entities. In response to these concerns, DSS and the PMO agreed to offer two tracks for MQISSP applicants as outlined on page 35.

The complete response and a summary documents are available at the following links:

Response to Concerns

Summary of Response to Concerns

4. Focus Populations

Person-centeredness has been a foremost consideration in the design of CCIP. The PTTF considered state and national model programs that designed interventions around specific populations. For the purposes of CCIP's design, the PTTF considered populations to be any grouping of people who share similar health conditions, racial or ethnic backgrounds, or socio-economic attributes. The focus on designated populations promotes person-centeredness to the extent that the care process addresses the individual values, preferences and goals of the patients within that population. The PTTF focused on populations that had a demonstrated need for improved care as evidenced by poor health outcomes,

unnecessary and preventable healthcare utilization, or a combination of both (The Center for Health Care Strategies, Inc., 2014) (Center for Health Care Strategies, Inc., 2015). Focus populations were only defined for the core capabilities and associated standards.

To address these demonstrated health needs, the PTTF sought recommendations that would enable Advanced Networks to adopt standardized, evidence-based best practices that would benefit patients across the state. At the same time, the PTTF also wanted to provide networks with the flexibility to tailor approaches to meet the unique needs of these patients in their local communities. These goals were paired with the objectives of CT SIM and the needs of the State more broadly to help identify the most appropriate focus populations for Advanced Networks.

To define the focus populations for CCIP the PTTF considered the following **criteria**:

#	Design Consideration Criteria	Why Is This Important?
1	Alignment with stated SIM goals	• Aligns CCIP with shared savings program rewards so that there is financial support for program investments
2	Alignment with needs of Connecticut	• Positions CCIP to advance Connecticut's population health goals while remaining payer agnostic
3	Standardization balanced with flexibility	• Ensures some level of consistency in how CCIP is implemented across networks • Promotes person-centeredness

Based on the above considerations, **three focus populations** were identified: (1) patients with complex health care needs, (2) patients experiencing equity gaps, and (3) patients with unidentified behavioral health needs. These populations were defined as follows:

> **Patients 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.
>
> **Patients Experiencing Equity Gaps**: Individuals belonging to a population experiencing poorer health outcomes with respect to a clinical condition, as compared to other individuals in the general population. For the first wave of CCIP, the intervention will focus on sub-populations defined by race and ethnicity, evaluating disparities in outcomes across the White, Black, and Latino populations. The intervention will further focus on diabetes, hypertension, or asthma, as these conditions are among the State's priority areas in the Department of Public Health's Chronic Disease Prevention and Health Promotion Plan[6] and are target areas for improvement in the SIM Provisional Quality Measure set. The identification of additional sub-populations defined by race, ethnicity, and sexual orientation/gender identity who are experiencing equity gaps will be encouraged.
>
> **Patients with Unidentified Behavioral Health Needs**: Any individual with a previously unidentified behavioral health need including mental health, substance abuse, or history of trauma.

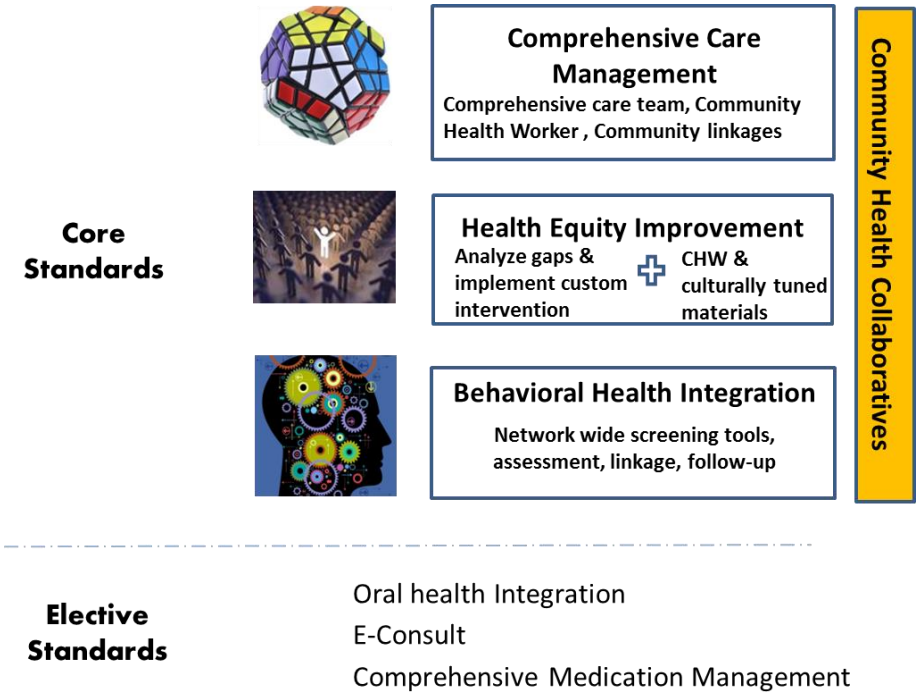
[6] http://www.ct.gov/dph/cwp/view.asp?a=3137&Q=543772

The table below provides a summary of how these focus populations align with the outlined design considerations:

Design Considerations	Focus Populations		
	Complex Health Needs	Health Equity Gaps	Behavioral Health Needs
Alignment with CT SIM and CCIP	• Reduce avoidable admissions and readmissions • Reduce ED use	• Reduce health equity gaps	• Improve behavioral health screening, access, and depression remission
Alignment with Connecticut Health Needs	• CT needs to better enable primary care practices to address complex health needs for broader patient populations	• There are known gaps in care in the state along racial and ethnic lines (Connecticut Healthcare Innovation Plan, 2013)	• 2013 OHA report on access to mental health identified deficits in routine recognition of mental health needs and access to services (Connecticut Office of the Healthcare Advocate, 2013)
Flexibility	• Networks will be able to define more specifically what "complex" means within their patient population • For example, Advanced Networks can create a risk stratification that identifies complex patients within their network populations	• The equity gaps will be defined to align with the equity gaps tracked on the quality scorecard • Within what is tracked, Advanced Networks will do an initial assessment to determine which area is most applicable amongst their patient populations	• Basic standards around the process to routinely screen and refer patients for behavioral health needs • Screening tools can be adapted/defined based on the behavioral health needs viewed to be most prevalent amongst the Advanced Network's patient population

5. Core and Elective Capabilities

After defining focus populations, the PTTF proceeded to define capabilities that are core to improving care for each population and the standards corresponding to these capabilities. The PTTF then designed a set of elective standards with broader applicability to attributed populations.



Core Standards for Focus Populations

Addressing public health concerns of the state was one of the primary considerations in selecting the three CCIP core standards which aim to address: (1) support for individuals with complex health needs; (2) health disparities; and (3) behavioral health screening, access and integration. The following facts describe some of the evidence of inadequacies of Connecticut's health care delivery system capabilities and the need for intervention:

- Consumers in our listening forums reported difficulty navigating the current healthcare system, especially those that have complex health needs.[7] Medicare data on readmission (including Medicare/Medicaid dual eligibles) places Connecticut in the bottom 30% of states in readmissions, avoidable ED use, and admissions for individuals with chronic conditions,[8] although care delivery and payment reforms undertaken by Medicaid, Medicare and other payers appear to be improving our performance.
- Gaps in care exist in the state along racial and ethnic lines, resulting in devastating outcomes. For example, African Americans in Connecticut die from diabetes at more than double the rate than their white counterparts.[9] Connecticut consistently ranks as having among the worst health disparities in the nation.[10]

[7] http://www.healthreform.ct.gov/ohri/lib/ohri/sim/plan_documents/ct_ship_2013_12262013_v82.pdf
[8] http://www.commonwealthfund.org/publications/fund-reports/2014/apr/2014-state-scorecard
[9] http://www.ct.gov/dph/lib/dph/hisr/pdf/2009ct_healthdisparitiesreport.pdf
[10] http://cdnfiles.americashealthrankings.org/SiteFiles/Reports/2015AHR_Annual-v1.pdf

- Recent survey found that physicians think it is very challenging to refer individuals for behavioral health treatment at nine times the rate that they find it very challenging to refer to other specialties.[11]
- The Office of the Healthcare Advocate report on behavioral health identifies deficits in routine recognition of mental health needs, access to services, and a lack of integration of mental health into primary care.[12]

Individuals with Complex Health Care Needs

In the background research for its complex care management standards, the PTTF examined a number of model programs that have excelled in the provision of care for individuals with extensive care management needs. This includes patients with potential social determinant risks such as unstable housing or joblessness. While not all of these programs were centered on the medical home, they did provide insight into better care management processes that could promote CCIP's focus on primary care enhancement. The primary care team in the medical home context consists of the patient, the patient's designated family members or other supports, a physician or APRN, and other staff of the medical home. As the complexity of the patient's needs increases, the primary care team may need additional participants such as a care coordinator, specialist, pharmacist, behavioral health specialist, or community health worker that act as extensions of the primary care for increased support and engagement. We refer to this enhanced care team as a **comprehensive care team**.

Acknowledging that the needs of patients change, CCIP sought to create a program that was an extension of the primary care team, which is the foundation for the care management process and the source of ongoing care when the comprehensive care team is no longer required. To that end, the PTTF derived lessons from other programs that shared a similar intensive care management design consisting of a care management team that deploys similar tools to provide intensive care management. This incorporated a focus on effective care coordination, the degree of which was tied to the complexity of the patient's needs. This also often included more effectively engaging patients in self-care management techniques while integrating primary care and community resources.

Success in these care management programs is accomplished when individuals are engaged in their care, feel supported by their providers, and have their full range of clinical and non-clinical needs addressed. These teams typically utilize needs assessments and care plans. The needs assessments are used to identify clinical, social, and behavioral health needs. A person-centered needs assessment and individualized care plan created by the comprehensive care team support the individual by ensuring transparency, portability, and continuity of information about health conditions, personal preferences, and goals of care (Spencer A, 2015) (Samuelson, 2015) (Hawthorne, 2015) (Health, 2014). At a high level the following **program design** is commonly used:

1. Identify the focus population;

[11] http://www.healthreform.ct.gov/ohri/lib/ohri/sim/steering_committee/2015-04-09/report_physician_survey_feb_2015.pdf
[12] http://www.ct.gov/oha/lib/oha/report_of_findings_and_recs_on_oha_hearing_1-2-13.pdf

2. Connect the individual to a comprehensive care team[13] charged with providing intensive care management;
3. Conduct a person-centered (see Appendix D for a list of definitions) needs assessment that informs the development of a care plan, with a focus on the individual's non-clinical (i.e.; social and behavioral) needs;
4. Execute the care plan, ensure updates are communicated to the care team, connect the individual to needed clinical and non-clinical services, and support the individual to transition to routine primary care team follow-up and self-directed care management; and
5. Track the individual, periodically reassess, and reconnect with the individual if needed.

A set of **design questions** was used to inform the creation of comprehensive care management standards for CCIP. The design questions included the following:

1. How should Advanced Networks identify complex patients?
2. Who will the core members of the comprehensive care team be? What will be their roles?
3. How will the Advanced Network build the comprehensive care team workforce?
4. What type of training will comprehensive care teams and primary care practices require?
5. What will the needs assessment and care plan look like? How will they be administered?
6. How will the comprehensive care team support the patient to successfully meet the care plan goals?
7. How can Advanced Networks monitor an individual's health status after they transition to self-directed care management?
8. How will the Advanced Networks monitor the effectiveness of the intensive care management intervention?
9. How will patient and caregiver preferences and input be incorporated into the care plan?

In answering these questions, the PTTF drew on best practices identified in related state and national programs and their individual expertise and experiences as providers, payers, and consumers of healthcare in Connecticut. The PTTF crafted a similar program design that aligns with evidence-based best practices but that parses out additional steps to ensure that the goals of patients with complex care needs are aligned with the right care team capable of accomplishing those goals.[14]

Patients Experiencing Equity Gaps

Connecticut is one of the most racially, ethnically, and culturally diverse states in the country. However, the State's performance on population health and quality measures varies greatly by race, ethnicity, geography, and income (Connecticut Healthcare Innovation Plan, 2013). We refer to disparities in outcome that are linked to such attributes as **health equity gaps**.

[13] Programs use multiple names for their care management teams, including: community care teams, integrated care delivery teams, community health teams, etc.

[14] The PTTF's findings to each of these design questions and additional design research can be found here: http://www.healthreform.ct.gov/ohri/lib/ohri/work_groups/practice_transformation/reference_library_/ccip_response_to_questions_pertaining_to_core_standards.pdf

The PTTF felt that it was important to establish Connecticut-specific standards for Advanced Networks and FQHCs to do continuous equity gap improvement. This would require networks to establish 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. For the initial purposes of CCIP, the standards are focused on identifying equity gaps across sub-populations defined by larger race and ethnic groups (White, Black, and Latino) and further limiting the assessment to identify gaps in outcomes for diabetes, hypertension, or asthma. These sub-populations are recommended for technical reasons (to ensure that populations are large enough to conduct statistically valid comparisons to show statistical differences) and programmatic reasons (to pick health outcomes that are aligned with the SIM Core Quality Measure Set). While the initial recommendation is to identify disparities across specific sub-populations for a specific set of health outcomes, the Advanced Networks will attain the skill set and technology required to routinely identify and address other disparities that may be prevalent in their communities[15].

The continuous equity gap improvement standards require a root cause analysis. If the root cause analysis reveals that the CCIP-defined intervention is not the best course of action, the Advanced Networks will have the opportunity to design their own intervention with the assistance of the technical assistance vendor. This will allow networks flexibility in customizing interventions and focus populations consistent with their local communities.

The PTTF also recommended standards for utilizing the support of a community health worker (CHW) to address equity gaps, which research has shown to be effective (Perez-Escamilla R, 2014) (Honigfeld L, 2012) (Anderson AK, 2005). CHWs can play a particularly important role in addressing equity gaps by virtue of the centrality of patient engagement to mitigating a specific equity gap. The training of CHWs to address equity gaps will include a component that covers culturally and linguistically appropriate education about specific diseases. They can also assist with establishing meaningful connections and relationships with community organizations to address social support needs.

Programs and randomized control trials that utilize CHWs to address equity gaps follow a similar intervention approach to the intervention for patients with complex needs:

1. Create a more culturally and linguistically sensitive environment
2. Establish a CHW workforce
3. Identify individuals who will benefit from the culturally attuned supportive services of a CHW
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 when an individual is ready to transition to self-directed care management

To design the standards for the health equity gap intervention, the PTTF considered the following questions:

1. How will the Advanced Network build the CHW workforce?

[15] For complete standards please see: Health Equity: Continuous Quality Improvement Standards in Appendix A.

2. How will the Advanced Network identify patients who will benefit from more culturally attuned support?
3. What will the care plan and needs assessment look like? And how will they be administered?
4. How will the CHW successfully support the patient to meet the self-care management goals?

The PTTF considered the best practices emerging from other CHW programs and research trials in addition to task force members' expertise and experiences as providers, payers, and consumers of healthcare in Connecticut in addressing these issues. As part of this inquiry, the PTTF also considered how to provide long-term funding for CHWs and how to integrate them into clinical teams in a sustainable way.[16]

Patients with Unidentified Behavioral Health Needs

A wealth of research exists concerning the positive impact on health outcomes and costs that can be achieved by better integrating behavioral health with primary care. Not only does better behavioral health management improve behavioral health outcomes, but it often also improves overall health status and reduces the overall cost of care (Brown D, 2014) (Community Health Network of Washington, 2013) (The CommonWealth Fund, 2014). The level of integration into primary care can vary, but often follows a common framework:

[16] The PTTF's findings to each of these design questions and additional design research can be found here: http://www.healthreform.ct.gov/ohri/lib/ohri/work_groups/practice_transformation/reference_library_/ccip_response_to_questions_pertaining_to_core_standards.pdf.

COORDINATED Key Element: Communication		CO-LOCATED Key Element: Physical Proximity		INTEGRATED Key Element: Practice Change	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/Merged Integrated Practice
Behavioral health, primary care, and other health care providers work:					
In separate facilities, where they:	In separate facilities where they:	In same facility not necessarily same offices, where they:	In same space within the same facility, where they:	In same space within the same facility (some shared space), where they:	In same space within the same facility, sharing all practice space where they:
• Have separate systems • Communicate about cases only rarely and under compelling circumstances • Communicate, driven by provider need • May never meet in person • Have limited understanding of each other's roles	• Have separate systems • Communicate periodically about shared patients • Communicate, driven by specific patient issues • May meet as part of a larger community • Appreciate each other's roles as resources	• Have separate systems • Communicate regularly about shared patients, by phone or e-mail • Collaborate, driven by need for each other's services and more reliable referral • Meet occasionally to discuss cases due to close proximity • Feel part of a larger yet ill-defined team	• Share some systems, like scheduling or medical records • Communicate in person as needed • Collaborate, driven by need for consultation and coordinated plans for difficult patients • Have regular face-to-face interactions about some patients • Have a basic understanding or roles and culture	• Actively seek system solutions together or develop workarounds • Communicate frequently in person • Collaborate, driven by desire to be a member of the care team • Have regular team meetings to discuss overall patient care and specific patient issues • Have an in-depth understanding of roles and culture	• Have resolved most or all system issues • Communicate consistently at the system, team, and individual levels • Collaborate, driven by shared concept of team care • Have formal and informal meetings to support integrated model of care • Have roles and cultures that blue or blend

Reference: (Brown D,

The level of integration pursued is dependent on the behavioral health needs being addressed. As might be expected, comprehensive management of patients with severe and persistent illness would more likely benefit from fully integrated care while patients with previously unidentified behavioral health conditions will likely benefit from a coordination model (Integrated Behavioral Health Project, 2013).

Given the focus on patients with previously unidentified behavioral health needs, the taskforce agreed that CCIP should create standards for a coordination model that outlines a consistent approach to:

1. Identifying when a patient has a behavioral health need
2. Determining if a referral is needed
3. Referring the patient to a behavioral health service when needed
4. Closing the communication loop between providers

To design this approach the PTTF considered the following design questions:

1. What tools should be used to screen for behavioral health needs in the primary care setting?
2. How to determine if an individual should be treated in the primary care setting or referred to a behavioral health provider?
3. What type of relationship will be required between the primary care providers and the behavioral health providers to ensure that referral processes, protocols and expectations are met?
4. How will the referral be tracked and the communication loop closed?

The PTTF considered the well-established best practices of behavioral health integration when addressing these core design questions.[17]

Elective Standards

The elective standards complement the core standards by providing an evidence-based framework for Advanced Networks that choose to pursue these capabilities to better meet patient needs. While these capabilities may not be universally applicable, the transformation vendor will be able to provide technical assistance in each of the areas.

- **E-consults:** The e-consults standards address gaps in access to specialty providers by establishing protocols for primary care providers to electronically consult with specialists. This model has been shown to decrease costs, increase access, and enhance primary care provider capabilities. Intervention standards were written in consultation with established practitioners in New England and with a review of the peer-reviewed literature.
- **Comprehensive Medication Management:** The CMM standards provide a framework for providers to engage patients with complex medication regimens to increase adherence and reduce complications. The standards were designed with input from practitioners at the

[17] The PTTF's findings to each of these design questions and additional design research can be found here: http://www.healthreform.ct.gov/ohri/lib/ohri/work_groups/practice_transformation/reference_library_/ccip_response_to_questions_pertaining_to_core_standards.pdf

University of Connecticut School of Pharmacy and informed by a review of the CMM guidelines published by the Joint Commission of Pharmacy Practitioners.

- **Oral Health:** The oral health standards are designed to increase oral health access and capabilities within the primary care setting to improve both oral and overall health. The oral health standards were written in consultation with the Connecticut Oral Health Initiative.

All intervention standards were reviewed and approved by the PTTF. The full core intervention standards can be found in Appendix A and the elective standards can be found in Appendix B.

Community Health Collaboratives

As it developed its recommendations for comprehensive care management, the PTTF recognized the need for standardized processes that link community and social service resources with traditional clinical providers in a given geographic area. The PTTF proposed the creation of **Community Health Collaboratives** composed of local stakeholders that would be tasked with developing protocols for better integration of shared resources into the provision of traditional healthcare services. The protocols will help standardize coordination and communication and enable more efficient care transitions. MQISSP participating Advanced Networks and FQHCs (including PTN participants) will be required to participate in these local collaborative efforts and adopt processes for care management and care transitions that align with the community-wide protocols. Community Health Collaboratives are further described in Appendix C.

6. Implementing CCIP Standards and Technical Assistance

The primary goal of the CCIP program is to ensure that participating Advanced Networks have the capabilities necessary to effectively support individuals with complex health care needs, to identify and reduce health equity gaps, and to better identify and support individuals with behavioral health needs. These CCIP capabilities are reflected in the core standards. SIM funded technical assistance is the primary means by which organizations will be supported in achieving these core capabilities as well as any elective capabilities that participating entities choose to pursue. The PMO will also pursue authorization from CMMI to use a portion of the SIM grant funds to provide transformation grants to CCIP participating entities.

Customized Technical Assistance

The SIM PMO intends to procure one or more vendors to provide the technical assistance to Advanced Networks to help them work towards achievement of the core standards. The technical assistance process will be customized so that participating entities receive support that is tailored to their needs. The vendor(s) will be responsible for conducting an assessment with each network to identify those areas where they do not meet the standards. The vendor(s) will work with the networks to develop a technical assistance plan that focuses on areas where there are gaps or opportunities for improvement.

Additionally, the transformation vendor will assess the feasibility of the Advanced Network fulfilling the core intervention standards over the 15-month support period based on the current state of the organization's capabilities. If it is determined by the vendor that it will not be possible to fulfill all core

standards over the 15 months, the vendor and the network will prioritize which standards will be implemented first, based on the needs of the network's population. The provider will be required to submit a plan for meeting the remaining standards on a timetable negotiated with the SIM PMO, but not to exceed six months. We anticipate that the start of the 15-month period will be January 1, 2017 for the first wave, even though the technical assistance contracts are expected to be executed in October or November of 2016.

If the standards do not fully align with needs of the Advanced Network and its patient populations, the PMO may work with the provider and vendor(s) to consider how the core standards might be adapted to better meet their population's needs. Furthermore, if networks are already fulfilling the needs of the focus populations and meeting minimum standards, then CCIP support will not be provided so as not to disrupt existing effective care coordination efforts.

It is important to note that CCIP is not intended to introduce new or separate programs different from those that participating entities may already have in place. Instead the effort is primarily intended to introduce new capabilities within existing programs or augment capabilities that may already exist, such as those associated with recognition as a PCMH. For example, we anticipate that many participating entities will already have care teams in place throughout their networks, but may not have effective processes for including community health workers as members of the team or linking with community supports to address an individual's non-clinical needs.

Change Management

To successfully execute the type of transformation associated with CCIP, many Advanced Networks may benefit from an understanding of the science of improvement, change management, and performance measurement. Accordingly, the transformation vendor will be expected to provide access to training and resources to support networks in their quality improvement efforts.[18] The vendor will work with the networks to ensure that the interventions are tested for effectiveness with an accepted methodology (e.g., Plan-Do-Study-Act, PDSA) before implementing and scaling the intervention network wide. Providers will be encouraged to include at least one CHW in the quality improvement team that conducts cycle of change testing for the interventions that propose CHW involvement, such as the elimination of healthcare disparities. The technical assistance vendor will also work with the PMO and the networks to identify opportunities to aggregate and report data on the effectiveness of these interventions to promote the population health goals of Connecticut.

The PMO will work with the transformation vendor(s) to develop curricula for the training that the vendor will conduct. In addition to training for participating Advanced Networks around change methodology, there will also be training around engaging patients, caregivers/families, and other healthcare partners in care and decision-making. Significant time and support is often needed to fully and effectively engage individuals as partners due to a variety of reasons including health literacy challenges and other social determinants.

[18] Quality improvement resources are also available from the American Hospital Association, the Centers for Medicare & Medicaid Services (CMS), and the Institute for Healthcare Improvement at no charge.

It is anticipated that the transformation vendor charged with providing technical assistance associated with comprehensive care management will also be responsible for initiating the Community Health Collaborative process. The vendor will convene the participating Advanced Networks and community stakeholders to develop the consensus protocols for coordination and a long-term sustainable plan for local oversight.

Specificity and Flexibility

The PTTF's approach to supporting the improvement of care provided by Advanced Networks follows the model developed by NCQA. Using this approach, the report specifies standards and provides sufficient detail to enable the provider to understand what needs to be done or, in some cases, how to do it. The level of detail was carefully considered by the Task Force. The standards generally reflect important components of each capability. For example, the Task Force felt that community health workers are an increasingly important element of our health care teams. Simply requiring a comprehensive care team without requiring the appropriate involvement of community health workers will likely limit the effectiveness of a team in addressing social determinant risks, the need for navigation assistance, or bridging cultural or language barriers. There is strong evidence that supports the inclusion of community health workers as a major element in two of the core standards (see Attachment B).

The CCIP standards build on local coordination efforts by focusing on enhancing current capabilities to achieve certain outcomes. For example, if practices in an Advanced Network assess patients without considering personal values, preferences and goals, we will work with them to include these important components of a truly person-centered assessment. Similarly, if the practices use care teams, but do not use community health workers, we will help the practices meet this element of the Comprehensive Care Team standard. In this way, the standards are flexibly applied and tailored to build on each Advanced Network's existing capabilities.

Despite the specificity contained within the standards, there remains a great deal of flexibility in how providers implement standards or achieve the goals associated with the standards. For example, we emphasize the use of continuous quality improvement techniques to identify health disparities and the use of root cause analysis to understand why those disparities exist. We are not prescriptive about how providers should address the issues that contribute to the disparities. This is one of many areas where there is plenty of room for innovation. An exception is our requirement that providers do a pilot intervention using community health workers to address at least one disparity related to chronic illness self-management. The evidence suggests that community health workers are one important means for addressing health disparities, so we aim to ensure that providers have figured out how to do this in the care of at least one clinical condition.

There are a few areas where our standards are quite prescriptive, such as the use of the PHQ-9 for depression screening and the effectiveness of treatment or what's called depression remission. There are good reasons to avoid requiring the use of a specific instrument. For example, there are often multiple standardized tools available to suit a particular purpose, practices may prefer to select a tool based on their view of a particular tool's strengths, and the pace of advancements in measurement science is such that new and better tools may arise in a relatively short span of time. These are among the reasons that DSS's policies generally support flexibility in choice of screening tool. In fact, DSS's

recommendations in this regard are the reason that the Quality Council endorsed a DSS customized measure of pediatric behavioral health screening rather than the only NQF endorsed measure, which requires the use of the Pediatric Symptom Checklist.

In the case of adult depression screening and CCIP standards, the Task Force wished to promote the adoption of the PHQ-9, which is a depression assessment tool that has become the national standard for depression outcome measurements. The PHQ-9 is the only instrument that meets the requirements of the new NQF endorsed measures for depression screening and remission (NQF 0710 and 1885). The inclusion of the PHQ-9 in our standards aligns the Advanced Network's care process with the measures recommended by the SIM Quality Council for use in value-based payment. It also aligns with the recently released recommended core measure set of the Core Quality Measures Collaborative, led by America's Health Insurance Plans, CMS, NQF and Chief Medical Officers and involving national physician organizations, employers, and consumers. The Core Quality Measures Collaborative recommends the use of both NQF 0710 and 1885 in value-based payment contracts with ACOs and PCMH.

The use of the PHQ-9 and the development of measures that rely on the PHQ-9 is a major advance in measuring the quality of care for depression. Currently, the most widely used method for measuring quality of care for depression is a measure of whether individuals are taking their medication (Anti-Depressant Medication Management (NQF 0105). By promoting the use of the PHQ-9 for initial screening and testing for depression remission, it will finally become possible to reward providers for the effectiveness of their treatment because the quality score is based on measured improvement in depression screening. This step forward in depression measures is consistent with the recommendations of measurement experts that we move away from process measures (taking your medication) to outcome measures (depression is better). We will edit the current Behavioral Health Integration standard to provide flexibility in choice of screening instrument in pediatric settings.

Finally, our approach to establishing Community Health Collaboratives envisions building on or using local collaborative structures where they exist. In Appendix C we note:

> *A survey of the existing health and healthcare related collaborative structures will be undertaken so that, where appropriate, our approach can mobilize existing partnerships and resources. For example, there are collaboratives in Connecticut that are comprised of diverse stakeholder groups focused on supporting more effective care transitions and reduced readmissions.*

The PMO does not intend to have the transformation vendor serve as convener where an acceptable alternative already exists. Moreover, we intend to learn from the successful pediatric care coordination collaboratives that have already been established in several communities throughout the state using an approach developed by the Help Me Grow Foundation.

CCIP and the Medicaid Quality Improvement & Shared Savings Program (MQISSP)

The Department of Social Services (DSS) will embed requirements related to CCIP standards within the Request for Proposals (RFP) through which DSS will procure Participating Entities for the Medicaid Quality Improvement & Shared Savings Program (MQISSP). DSS' reason for doing so is that it acknowledges the value of promoting activities that will promote and support the needs of Medicaid beneficiaries who are already being served by Advanced Networks.

DSS and the SIM PMO also agree, however, that it will be useful to test the CCIP standards. Therefore, in the first wave of MQISSP procurement for the project period starting January 1, 2017, DSS and the SIM PMO have agreed permit applicant entities to choose whether or not they will be bound by the CCIP standards. The DSS MQISSP RFP will offer two tracks, from which applicant entities must choose. The first track will require Participating Entities to participate in CCIP technical assistance, but will not require demonstrated achievement of the CCIP standards as a condition for continued participation in MQISSP. The second track will enable Participating Entities to indicate that they agree to be bound by CCIP standards. Only second track participating entities will be eligible for potential transformation awards.

Over the course of the first MQISSP performance period, DSS and the SIM PMO will carefully review the experience of Participating Entities that agree to be bound by the CCIP standards, will seek additional comment on the CCIP standards, and may adjust the CCIP standards, as needed. For the second wave MQISSP procurement, achievement of the CCIP standards, as revised, will be a condition for all MQISSP Participating Entities, including those entities that were exempt during the first wave.

The PMO will endeavor to keep the best interests of Medicaid beneficiaries at the forefront as it supports CCIP participating entities in working towards the achievement of CCIP standards. This will be accomplished through our agreements with the transformation vendor as well as our agreements with the Participating Entities. For example, the Participating Entities will be required to develop Medicaid specific coordination protocols as described further below and the transformation vendor will be required to include the development of such protocols as an element of its technical assistance. Furthermore, the Participating Entities will be encouraged to alert the transformation vendor to areas where the CCIP standards or elements might conflict with DSS requirements or their ability to otherwise effectively serve Medicaid beneficiaries. The PMO is proposing an exception or accommodation process with respect to circumstances of this kind. This is further discussed in the sections below regarding coordination with DSS programs and the summary of accommodations.

POLICY	TRACK 1	TRACK 2
CCIP commitment	Respondents commit to participate in the CCIP TA program, which will be tailored to their individual needs, but are <u>not</u> required to achieve the CCIP core standards until 15 months from the start date of the second wave of MQISSP	Respondents commit to participate in the CCIP TA program, which will be tailored to their individual needs, <u>and</u> to achieve the core CCIP standards within 15 months of the MQISSP start date (anticipated to be 1/1/17)
MQISSP RFP requirements	Respondents will be asked to describe how they will organize and manage the transformation process and work with the TA vendor to *make progress toward* the core standards	Respondents will be asked to describe how they will organize and manage the transformation process and work with the TA vendor to *achieve* the core standards

Funding	Respondents will receive no-cost TA and will have the opportunity to participate in a learning collaborative, but are not eligible for SIM-funded transformation awards	Respondents will receive no-cost TA, will have the opportunity to participate in a learning collaborative, and will have the opportunity to apply for up to $500,000 per applicant in SIM-funded transformation awards
Compliance monitoring	Respondents will be surveyed regarding their progress on activities related to the standards, for purposes of PMO reporting to CMMI	Respondents will participate in a validation survey; achievement of standards will be a condition of continued participation in MQISSP
Accommodations	N/A	Providers that elect to be bound by the CCIP standards may request a waiver or accommodation with respect to specific requirements listed in the "Summary of Accommodations" below.

MQISSP and CCIP align with the payment and care delivery reforms that more and more Advanced Networks have encountered by virtue of their participation in value-based contracts with Medicare and commercial payers. Together, this set of incentives and new capabilities will enable Advanced Networks to improve the overall efficiency and effectiveness of patient care for all of the populations for which they are responsible.

Coordination with other DSS and Community Initiatives

As noted earlier, the CCIP standards build on local coordination and care delivery capabilities by focusing on enhancing these capabilities to achieve the outcomes set forth in the standards. For example, if practices in an Advanced Network assess patients without considering personal values, preferences and goals, we will work with them to include these important components of a truly person-centered assessment. In this way, the standards are flexibly applied and tailored to build on each Advanced Network's existing capabilities. In addition, this approach ensures that CCIP will not introduce duplicative efforts or structures.

DSS PCMH Program:

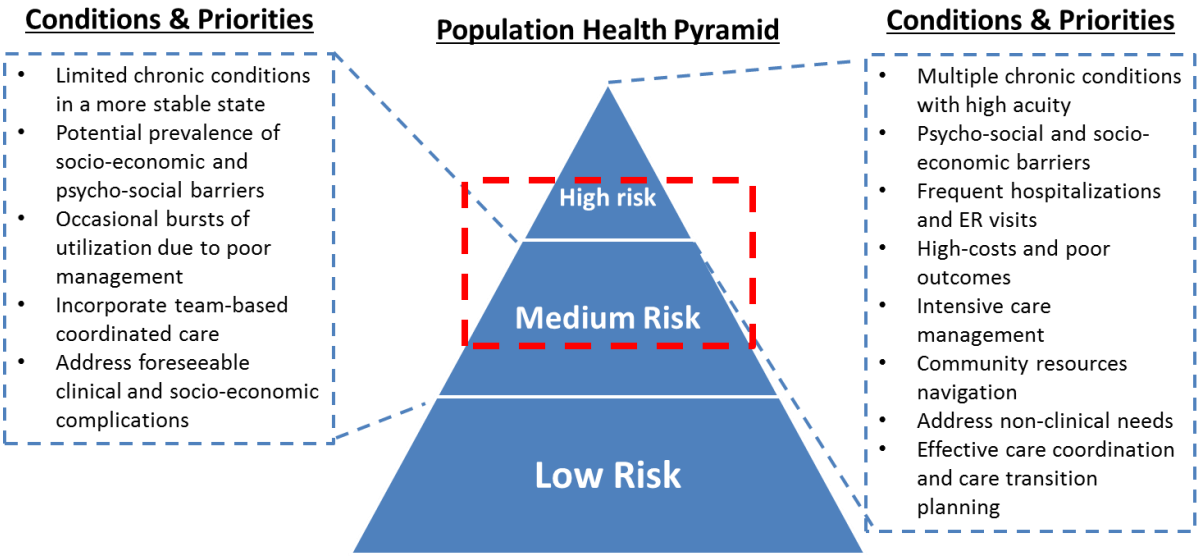
In developing the standards, the Task Force was aware of the foundational capabilities reflected in the NCQA PCMH model, which are also central to the AMH program (which the Task Force also designed). The CCIP standards were intended to complement the PCMH program standards, and in some cases, to require activities that under PCMH are optional. For example, PCMH standard 3.B.5 "Maintains agreements with behavioral healthcare providers" is optional in the PCMH standards, but a requirement

of this type is included in the CCIP Behavioral Health Integration standard (BH.2.e) if the Advanced Network does not have behavioral health providers as part of its network.

Despite our efforts to ensure compatibility, we recognize that there may be unforeseen ways that the PCMH and CCIP standards could potentially be in conflict. For this reason, we will allow an Advanced Network to request an exemption from or adjustment to a CCIP requirement that conflicts with, or would otherwise disrupt, their activities in relations to a PCMH standard.

DSS Intensive Care Management (ICM) Program:

The CCIP Comprehensive Care Management standard aims to improve Advanced Networks' care management services. Our work will focus on improving performance by working with Advanced Networks to make the assessment process more person-centered such as by asking about value, preferences and goals and behavioral health conditions and social factors that might affect care outcomes. We also focus on ensuring the inclusion of key members of the *comprehensive care team* when appropriate such as community health workers and behavioral health professionals. This work also includes ensuring that the medical home care plan can be extended to describe the activities of new team members, such as linking to community services. We anticipate that providers will be able to serve more effectively individuals with complex health needs as a result of these enhancements. In essence, providers will be better able to manage the care of individuals who fall in the medium risk area of the figure below, and in some cases, even some of the higher risk individuals.



Many payers have programs that are also focused on individuals in the medium to high risk areas. For example, DSS has a successful Intensive Care Management (ICM) Program administered by the Community Health Network of Connecticut (CHNCT). The goal of this program is to support the development of health goals and improved outcomes for Medicaid beneficiaries who are identified as high need based on the results of CHNCT's predictive modeling tool, CareAnalyzer, outside referrals, and

self-referrals. The program includes nurse care managers in geographic teams as well as peer supports to help individual's achieve their goals. In addition, ICM is not unique to the medical ASO—it is also performed by the behavioral health ASO, Beacon Health Options, and involves community care teams and peer supports. The Connecticut Dental Health Partnership (dental ASO) has a related program that employs community engagement specialists and focuses on federal grant-funded integration of dental care within pre-natal and pediatric visits.

As Advanced Networks grow their care management capabilities, the following situations might occur:

a) Advanced Network identifies individuals for comprehensive care management who might otherwise have been identified and served by the CHNCT ICM Program,

b) Advanced Network identifies individuals for comprehensive care management who are already being served by the CHNCT ICM Program (or the opposite),

c) Advanced Network and CHNCT both identify the same high need individual at the same time.

In the first example, the team that first identifies the patient needs to consider who is best situated to address the individual's complex health needs. This determination depends on the capabilities of the medical home's comprehensive care team and the nature of the individual's health needs. Let's consider the following case example:

> B.A. is a recently un-employed 58-year-old man with a 5-year history of type 2 diabetes. He is divorced with a daughter and several grandchildren. He was identified as a candidate for care management using health risk stratification software, which based his risk on suboptimal diabetes control and a number of co-morbidities including obesity (BMI 32.4 kg/m2), hyperlipidemia, peripheral neuropathy (distal and symmetrical by exam), hypertension (by previous chart data and exam), and elevated urine micro-albumin level. A person-centered assessment identified strengths associated with his strong investment in being a part of the lives of his grandchildren and a few friends that he sees occasionally for bowling. He had identified limitations in health literacy and attempts to lose weight and increase his exercise for the past 6 months without success. There were opportunities for improvement in the areas of self-care management and lifestyle, exercise, and understanding of diabetes. Financial difficulties placed him at risk of losing his housing and contributed to his inconsistent eating patterns as well as episodic depression.

The Advanced Network employs a nurse care manager with training in motivational interviewing. The team has access to community health worker with skills in chronic illness self-management training and the relationships with community supports such as housing. A licensed clinical social worker is also part of the team and available to see the patient at the primary care clinic or at her private office. It appears based on this presentation, that this patient's complex health needs can be effectively managed with an enhanced medical home team, which we refer to as a comprehensive care team when expanded to include the social worker, community health worker, a nutritionist and the patient's daughter. The medical home care plan has additional modules to establish goals and activities to support coordination of care, lifestyle changes, and behavioral health.

If B.A.'s challenges were limited to the above, we might expect a positive outcome. The medical home's coordination enables face-to-face visits when needed, supplemented by home-visits by the community health worker focused on chronic illness self-management, including diet and exercise. If the patient had other co-occurring conditions, such as poorly controlled bi-polar disorder or abuse of chronic pain medications, or a change in condition, such as a stroke or serious cardiac problems, the complexity might require a referral to the CHNCT's ICM program, potentially with Beacon Health Options providing adjunct support. In this case, lead care coordination responsibilities might begin with or transition to the ICM care management lead, who would handle care management during the acute phase of the individual's instability or longer, if ICM level support is needed ongoing. The ICM would develop a care plan that wraps around the care plan of the medical home and includes coordination with hospital, nursing facility or local mental health authority, as needed to optimize recovery. The medical home supports such as the nutritionist and community health worker could continue to be available, however, the care management would be provided by the ICM program.

We believe that it is important to require that Advanced Networks participating in CCIP develop coordination protocols with CHNCT and Beacon Health Options that set mutually agreeable processes for handling the above situations. The protocols could specify, for example, how individual choice should factor into decisions about who leads the care management process and for which individuals one or another program might be better suited. In addition to requiring these coordination protocols, we will allow an Advanced Network to request an exemption from or adjustment to a CCIP requirement that conflicts with, or would otherwise disrupt, their ability to work effectively with the CHNCT or Beacon Health Options' ICM programs.

We recognize that DSS envisions the CHNCT ICM program may be gradually reduced over time as Advanced Networks and FQHCs become better able to manage individual care management needs more effectively, including for individuals who may be high risk. However, as that process evolves, it is important that Advanced Networks, FQHCs and CHNCT can coordinate their respective efforts to ensure that the evolution occurs in a manner that is in the best interest of Medicaid beneficiaries. We look forward to learning from these important early efforts and adjusting the program to reflect what we learn.

Coordination with Other Cross-Sector Initiatives

The above example of coordinating with the DSS ICM program applies to other coordination programs that might already exist outside of the Advanced Network or FQHC. We would propose to follow a similar process in examining coordination issues that might arise with these other programs as they are identified.

For example, Advanced Networks may use the care coordination services of the DPH Children and Youth with Special Health Care Needs (CYSHCN) care coordination centers as an adjunct to their medical home care coordination services. Funded by the federal Maternal and Child Health Grant, the CYSHCN program funds five regional care coordination centers to support pediatric primary care providers in

linking children to health and community services. Care coordination services are provided to children regardless of age and insurance coverage. The care coordination centers also convene care coordination collaboratives that bring together all of the care coordinators for children from the array of child serving sectors, including health, mental health, dental, child welfare, education, etc. These collaboratives ensure that DPH CYSHCN care coordinators can address the social determinants of health and that care coordinators from the other sectors can connect children and families to health services.

Access to the regional care coordination centers is available through United Way's 211 Child Development Infoline (CDI), which practices may use to link children and families to developmental services under Part C of the Individuals with Disabilities Education Act (IDEA) Early Intervention Services, Part B of IDEA Preschool Special Education Services, and Help Me Grow Services. Help Me Grow is a statewide system of developmental promotion, early detection of children at risk for delays and linkage to services, especially for children who are not eligible for publically funded intensive services, such as those covered under Part C and Part B of IDEA. Help Me Grow began in Harford, was extended statewide with funding from the legislature, and now is in 25 states.

CDI, Connecticut's single point of entry for young children's service, is funded through the blending of federal and state administrative and financial resources from three state agencies (Office of Early Childhood, Department of Public Health and State Department of Education). It triages calls from families, child care sites, schools, and pediatric primary care providers. Advanced Networks can access a broad of services for their pediatric patients through CDI without struggling through complicated funding streams, eligibility requirements and insurance issues.

We have begun discussions with Connecticut Children’s Medical Center (CCMH) regarding the Hartford Care Coordination Collaborative. It appears that the care coordination arrangements associated with HCCC and used by pediatric practices is effective for many children. We are prepared to continue our work with CCMC to develop any necessary coordination protocols between pediatric practices and HCCC or similar collaboratives in other regions of the state, and potentially to use our CCIP technical assistance process to expand awareness of and linkage with the HCCC and other collaboratives. Moreover, CCMC and the Child Health and Development Institute (CHDI) have offered to lend us their expertise in developing a systems approach to multi-stakeholder collaboration of the sort envisioned in the CCIP Community Health Collaboratives. We are eager to learn from their experience.

We have also had discussions with leadership at the Clifford Beers Child Guidance Clinic about their impressive work with Wraparound New Haven. This program is targeted to children with co-occurring medical and behavioral health needs and it provides a range of supports to the child and family, including assistance with social factors that might affect health care outcomes and recovery. CCIP requires that Advanced Networks and their practices develop the capability to do care coordination and to work as a medical home team. However, the standards do not require that the practice do so for all of their patients who need care coordination. It is entirely appropriate for practices to use available community resources that can meet the needs of children and families, and rely on their own resources when the needs are moderate or when community capacity is limited.

Most importantly, we believe that the CCIP process will identify more children who would benefit from available community supports such as HCCC or Wraparound New Haven, improve awareness of such supports, and foster the practices ability to effectively refer and link to these supports.

Finally, DCF has contracted with Beacon Health Options to serve as the Care Management Entity for children with serious behavioral health needs. The program includes a team of Intensive Care Coordinators and Family Peer Specialists to provide services in accordance with the Wraparound Milwaukee model. Most of the Intensive Care Coordinators are co-located at DCF offices and only accept referrals from DCF staff. A couple of Intensive Care Coordinators identify children in emergency departments. None of the Intensive Care Coordinators accept outside referrals. This Intensive Care Coordination program is geared to the special populations that represent the tip of the above Population Health Pyramid. The Task Force has not proposed in CCIP that Advanced Networks take on the highly specialized care management needs of these and other special populations. The same is true of waiver programs administered by the Departments of Developmental Services, Social Services, and Mental Health and Addiction Services, which also focus on populations with highly specialized care coordination needs and which typically are not based on the medical home team.

We believe that all of the above underscores the importance of ensuring that practices have tools that provide up-to-date information about available community resources, the need for which will be identified in the person-centered assessments.

Costs Associated with Meeting the CCIP Standards

We recognize that there are additional costs associated with meeting the CCIP standards. For a number of reasons, we believe that it is reasonable to expect Advanced Networks to make these investments and we also believe that there are ways some of these costs can be offset as follows:

- We are relying to some extent on the willingness of organizations to incur some costs in their efforts to meet the standards with the expectation that there will be a return on investment in the form of shared savings. This is the same thinking that Medicare used for the Pioneer ACO and Medicare SSP initiatives. Many of the organizations that participated in these programs, especially the Pioneer ACO program, achieved significant shared savings that helped offset their investments in organizational improvement. Notably, organizations that participate in CCIP will have the opportunity to recoup their investments in all of their shared savings program arrangements, whether Medicare, Medicaid or commercial.
- Part of the cost of transformation is offset by providing free technical assistance. CCIP participating entities will have access to SIM funded technical assistance resources and learning collaborative support. The subject matter expertise, guided transformation planning and assistance, and structured peer-to-peer learning will be at no cost to the Advanced Networks.
- In addition, are seeking authority from CMMI to provide transformation awards for track 2 participating entities, likely no more than $500k (and potentially dependent on the size of the

Advanced Network and population served), which should mitigate some of the expenses they incur.

We further recognize that the CCIP standards are new and that there is value in a staged approach to implementation—one that allows time to make program adjustments before all MQISSP Participating Entities are required to meet the standards. For this reason, DSS and the PMO developed the two track approach that allows applicants in the first wave to choose whether or not they will be bound by the CCIP standards. Our proposed approach to CCIP also provides some flexibility that can lessen the cost of transformation including the following:

- We propose to introduce community health workers and the heath equity pilot in a limited subset of practices so that the return on investment (quality and cost) can be demonstrated before adopting these interventions more widely.
- Our CCIP report currently allows some accommodation on the timeframe, which would allow costs to be spread out over time.
- We will consider modifying specific requirements if the costs associated with meeting them present an insurmountable barrier. An example would be a provider that has no analytic software that enables them to tap their EHR for health risk stratification. In this case, we might adapt the Comprehensive Care Management standard re: health risk stratification to make best efforts with claims based data, perhaps with non-automated information gathered with respect to social determinant risks.

Finally, we recognize that there may be some organizations for which the CCIP standards will be too much of a stretch. If we believe these capabilities are important to addressing the needs of patients with complex health needs, cultural/language barriers, social-determinant risks, and behavioral health conditions, it is reasonable to select for those organizations that are prepared to meet them

Summary of Accommodations

DSS and the PMO recognize that the CCIP standards are new and untested and, as such, some flexibility in their application may be necessary in the initial stages of implementation, especially for participating entities in Track 2. A number of accommodations have been discussed in the preceding narrative as follows:

- Requirement Accommodation: Participating entities can request an exemption from or adjustment to a CCIP requirement that conflicts with, or would otherwise disrupt, their activities in relation to DSS programs such as PCMH or the CHNCT or Beacon Health Options ICM Program.
- Hardship Accommodation: Participating entities can request an accommodation if the costs associated with meeting a requirement presents an insurmountable barrier.
- Timetable Accommodation: Participating entities in Track 2 may request an additional 6-months to meet CCIP standards.

- Alignment Accommodation: Participating entities can request an accommodation if a requirement does not fully align with the Advanced Network's care delivery model and the needs of its patient populations.

Enforcement

As noted above, our agreement with DSS is that only a subset of Advanced Networks participating in wave 1 of MQISSP—those that elect to do so—will be required to achieve the core standards within 15 months of wave 1 implementation. Advanced Networks in this subset must be in good standing with respect to achieving and maintaining compliance with CCIP standards as a condition of continued participation in MQISSP. This condition is the most important means to sustain the changes in practice associate with the CCIP standards, recognizing that sustainability is a major emphasis of CMMI.

The SIM PMO will monitor program participation and designate Advanced Networks that are either a) participating entities in good standing with our technical assistance and making progress toward the achievement of CCIP standards, or b) have achieved compliance with the core standards. The PMO contract with the transformation vendor will include provisions for assessing participation during the transformation process and achievement of the core standards at the end of the transformation period and potentially at one or more follow-up intervals. The PMO will use this information as the basis for certification or designation and the status of each participant will be communicated to DSS at established intervals.

Impact on Advanced Networks and their Affiliated Practices

The CCIP standards are focused on Advanced Networks, rather than individual practices. As noted previously, DSS has agreed to embed requirements related to CCIP standards within the Request for Proposals (RFP) through which DSS will procure Participating Entities for MQISSP, beginning in the first wave with a two track approach. By requiring that Advanced Networks meet the CCIP standards, Medicaid will be helping to raise the standard of care for all populations served by these organizations and their affiliated practices. The same is also true of DSS's requirement that practices achieve PCMH recognition. This requirement raises the standard of care within individual practices, regardless of whether and to what extent the individual clinicians that comprise the practice see Medicaid patients.

The PMO intends to engage commercial payers in discussions about considering the CCIP standards when negotiating transformation payments with Advanced Networks. It is important to note that some of Connecticut's commercial payers already contribute to the ability of Advanced Networks to undertake care delivery reforms by making these transformation payments.

Applicability to All Providers and Populations

The CCIP standards are focused on accountable health care organizations, which we refer to as Advanced Networks, rather than individual practices. DSS has agreed to embed requirements related to CCIP standards within the Request for Proposals (RFP) through which DSS will procure Participating Entities for MQISSP, beginning in the first wave with a two track approach. By requiring that Advanced

Networks meet the CCIP standards, Medicaid will be helping to raise the standard of care for all populations served by these organizations and their affiliated practices. The same is also true of DSS's requirement that practices achieve PCMH recognition. This requirement raises the standard of care within individual practices, regardless of whether and to what extent the individual clinicians that comprise the practice see Medicaid patients.

As noted earlier, the CCIP standards place an emphasis on individuals with complex health needs and patients with social factors that are barriers to care. These problems are especially common in low-income populations such as those served by the Medicaid program. For this reason, we believe that CCIP is a program that is very much in the best interests of Medicaid beneficiaries that are participating in MQISSP.

Complex health needs and social determinant risks are even more prevalent in the Medicare/Medicaid dual eligible population. This population is not eligible to participate in MQISSP. If dual eligibles are receiving care from an Advanced Network, there is a high likelihood that the individual is participating in the Medicare "ACO" Shared Savings Program. By requiring Advanced Networks to meet CCIP standards, DSS is making sure that Medicare ACOs are improving care coordination, reducing health equity gaps, addressing social determinants risks, and integrating behavioral health, all of which are of central importance for Medicare/Medicaid eligible consumers. For this reason, we believe that CCIP is a program that is very much in the best interests of Medicare/Medicaid beneficiaries, even if they are not participating in MQISSP.

The PMO intends to engage commercial payers in discussions about considering the CCIP standards when negotiating transformation payments with Advanced Networks. It is important to note that some of Connecticut's commercial payers already contribute to the ability of Advanced Networks to undertake care delivery reforms by making these transformation payments.

Promoting the Best Interests of Medicaid Beneficiaries

As noted earlier, the CCIP standards place an emphasis on individuals with complex health needs and patients with social factors that are barriers to care. These problems are especially common in low-income populations such as those served by the Medicaid program. For this reason, we believe that CCIP is a program that is very much in the best interests of Medicaid beneficiaries that are participating in MQISSP.

Complex health needs and social determinant risks are even more prevalent in the Medicare/Medicaid dual eligible population. This population is not eligible to participate in MQISSP. If dual eligibles are receiving care from an Advanced Network, there is a high likelihood that the individual is participating in the Medicare "ACO" Shared Savings Program. By requiring Advanced Networks to meet CCIP standards, DSS is making sure that Medicare ACOs are improving care coordination, reducing health equity gaps, addressing social determinants risks, and integrating behavioral health, all of which are of central importance for Medicare/Medicaid eligible consumers. For this reason, we believe that CCIP is a program that is very much in the best interests of Medicare/Medicaid beneficiaries, even if they are not participating in MQISSP.

Although the CCIP standards appear to be inherently beneficial to Medicaid beneficiaries, the PMO will, through the support provided to participating entities, endeavor to keep the best interests of Medicaid beneficiaries at the forefront.

Coordination with Practice Transformation Network Grant Participants

SIM and PTN are federally funded programs, both of which include a focus on practice transformation and technical assistance. CMMI has instructed SIM and PTN grant recipients to work together to coordinate the administration of these programs with the aim of promoting harmonization and ensuring that duplication is avoided. The SIM PMO and the Department of Social Services (DSS) have worked with Connecticut's PTN grantees to formulate key principles for coordinating the two programs. The principles below are based on discussions with Community Health Center Association of Connecticut (CHCACT), the lead agency for Connecticut's FQHC participants, and UConn Health, as a participant of the Southern New England PTN.[19]

Key Principles

1. The SIM and the PTN programs emphasize related capabilities focused on team-based care management, population based analytics and performance improvement, and integrated behavioral health. In order to avoid duplication and maximize the total number of clinicians in Connecticut that can be supported by these transformation initiatives, providers shall not be permitted to participate in both SIM and PTN funded transformation support in these overlapping core content areas. SIM funded technical assistance and transformation awards with this focus shall be limited to entities/clinicians that are not participating in PTN.
2. The SIM program also focuses on content areas related to e-consultation and the use of Community Health Workers in support of clinical care, navigation and access to community supports. Neither e-consultation nor Community Health Workers are content areas within the CHCACT PTN program. Accordingly, SIM funded technical assistance and the SIM CHW initiative may be available to support interested entities/clinicians that are participating in PTN. SIM and CHCACT PTN program leads agree to make good faith efforts to examine the extent to which this can be achieved to mutual advantage and within available resources. UConn Health does include e-consultation as a content area and will not duplicate any technical assistance provided under SIM. UConn Health is also developing an initiative to bring geriatric expertise both to primary and a specialty practices, for which there is no counterpart SIM, but which might help inform SIM's transformation initiatives.
3. Statewide transformation efforts should present a unified approach and should not create silos amongst practices. The SIM and PTN program administrators will work to promote harmonization in the design of these programs. The PTN program administrators will work in collaboration with the SIM PMO to review the SIM Community and Clinical Integration Program (CCIP) standards and consider whether and to what extent these standards could be incorporated into the PTN change package in a manner that will advance the programs' mutual

[19] Discussions have also been held with VHA/UHC, however, the VHA/UHC clinician recruitment plan does not currently include Connecticut-based clinicians.

aims and without adding undue burden on the program participants. The SIM PMO will do the same with the PTN standards and change package to the extent such information is available timely.

4. SIM and PTN should adopt a strategy that avoids unnecessary burden on the provider. Transformation assistance should be tailored to focus on the gaps in participants' capabilities, rather than a "one-size-fits-all" approach that requires all providers to participate in all aspects of the change package.
5. The Medicaid Quality Improvement and Shared Savings Program (MQISSP) is a SIM related initiative that is intended to build on current success with the Medicaid PCMH and Intensive Care Management initiatives by incorporating advanced care coordination elements within a shared savings model. None of the principles outlined above are intended to preclude PTN providers from applying to participate in MQISSP if they otherwise meet DSS's eligibility requirements. DSS and the PMO encourage FQHCs and other PTN participants to consider applying to participate in MQISSP and recognize that PTN resources may better enable PTN participants to achieve MQISSP care improvement goals.

Enabling Health Information Technology

Many of the capabilities promoted in CCIP depend on health information technology. The SIM model test grant proposes funding a menu of technology tools that could serve as enablers to participating Advanced Networks. An example of this is the technology necessary to support the deployment of electronic admission, discharge, and transfer alerts. Other technologies will be required, funding for which will be the responsibility of the providers and which will likely require ongoing development and associated investments. The SIM PMO, DSS and the UConn Health Information Technology (HIT) team will work with the HIT Council and PTTF to further define those program needs where SIM funded technology would be most appropriate. The PMO will also examine commitments to participate in such technology solutions that might be required as a condition of participation in CCIP.

Appendices

Appendix A: Community & Clinical Integration Program – 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 supports[20] collaborate to develop the individualized care plan[21] 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

[20] Natural supports include but are not limited to, family, clergy, friends, and neighbors
[21] See Appendix F for examples of person-centered care coordination plans

iii. Establishes social health goals to address social determinant risks
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 data[22]
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., dieticians, 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:

[22] 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)

   i. Identifying values, principles and goals of the comprehensive care team intervention
   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 approaches[23]
   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 attend[24]
   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

[23] 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.
[24] Best practice suggests all members of the comprehensive care team and relevant primary care team members

iii. Developing a standardized progress note that documents key information obtained during the touch points
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 support[25]
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 team[26]

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)[27]
   ii. Achieving improved performance on identified measures

[25] See Appendix F for sample tool
[26] The network could consider utilizing a ED/Inpatient admission/discharge alert technology for monitoring
[27] 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

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
   iii. Establishing a method to share performance[28] 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 population[29]
c. The network implements at least one additional network capability to support the comprehensive care team process.

[28] 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
[29] 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 benchmark[30]
   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

[30] 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.

4. **Evaluate whether the intervention was effective**
   a) The network demonstrates that the intervention is reducing the healthcare disparity identified by:
      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 performance[31] 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

[31] 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 assessment[32]

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

a. The CHW and the individual and their natural supports[33] 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 change[34]
   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 date[35]
b. The network defines a process and protocols for the CHW to create the person-centered self-management plan including location and timeframe for completion[36]

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 attend[37]
   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 risks[38]

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[32] 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

[33] Natural supports include but are not limited to, family, clergy, friends, and neighbors

[34] 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

[35] See Appendix F for examples from other programs

[36] 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

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

[38] 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

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
c. The network modifies its process for exchanging health information across care settings to accommodate the role and functions of the CHW support[39]
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

[39] 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 needs[40]

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 degree[41] 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 own[42]

[40] The screening is not intended to identify individuals with severe and persistent mental illness
[41] 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.
[42] 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 assessment[43] 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 visit[44]
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 include[45]
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 considers[46]:
   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

[43] The assessment should reflect the needs identified by the screening tool.
[44] This re-screening could include questions asked about changes by doctor or nurse as part of routine visit.
[45] 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)
[46] 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.

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.[47]
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 treatment[48].
   ii. Guidelines on how information will be exchanged and within what timeframe
   iii. Designating an individual to be responsible for tracking and confirming referrals[49]
   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 completed[50]
   vi. Appropriate coding and billing[51]

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 includes[52]:
   i. Who is responsible for updating
   ii. Defining intervals at which assessments are made
   iii. Adjusting treatment when not effective

[47] 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).
[48] 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.
[49] Consider a designated behavioral health referral coordinator
[50] Completed means the consultation occurred and information on the consultation was shared with the primary care practice
[51] Pending policy developments around same day billing for behavioral health services may alleviate the need for this to be required of the MOU
[52] Consider technological solutions for tracking outcomes such as a disease registry

Appendix B: Community & Clinical Integration Program – Elective Standards

ELECTIVE STANDARD 1:
ORAL HEALTH INTEGRATION

Program Description and Objective:

Description: It is well documented that there is an oral-systemic link (Qualis Health, 2015). The oral health integration standards provides best-practice processes for the primary care practices to routinely perform oral health assessment with recommendation for prevention, treatment and referral to a dental home.

Objective: To improve oral for all populations with its associated impact on overall health. An individual's oral health affects their overall health and vice versa, in particular when individuals have certain chronic diseases such as diabetes, obesity, lung and heart diseases, as well as affected the birth outcomes. These standards put into primary care practices processes that promote treating the individual that acknowledges the oral-systemic link.

High Level Intervention Design:

1. **Screen individuals for oral health risk factors and symptoms of oral disease**
2. **Determine best course of treatment for individual**
3. **Provide necessary treatment – within primary care setting or referral to oral health provider**
4. **Track oral health outcomes/improvement for decision support and population health management**

1. **Screen individuals for oral health risk factors and symptoms of oral disease**
   a. The network develops a risk assessment[53] that will be reviewed by the primary care provider to screen all individuals for oral health needs using a tool that includes questions about:
      i. The last time the individual saw a dentist and the service received
      ii. Name of dentist and location/dental home if available[54]
      iii. Oral dryness, pain and bleeding in the mouth
      iv. Oral hygiene and dietary habits
      v. Need and expectations of the patient
   b. The network determines a process and protocol to administer the risk assessment that identifies:
      i. The format of the assessment (i.e.; written or verbal)
      ii. Who administers the assessment (can be anyone in the practice)
   c. The network identifies a process to flag individuals for follow-up for further evaluation and basic intervention that includes the primary care based preventive measures detailed in section two
   d. The network develops an oral examination[55] procedure of the entire oral cavity that includes:

[53] See Appendix F for a link to sample risk assessments
[54] A "dental home" means an ongoing relationship between a dentist and an individual, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated and person or family-centered way (reference: Connecticut Dental Health Partnership (CTDHP) Dental Home Definition)
[55] See Appendix F for sample Oral Exam

   i. Assessment for signs of active dental caries (white spots or untreated cavities)
   ii. Poor oral hygiene (presence of plaque, or gingival inflammation
   iii. Dry mouth (no pooling saliva and/or atrophic gingival tissues)
   iv. Lesions including pre-cancer and cancerous lesions.
e. The network determines who is responsible for conducting oral exam[56] and ensures appropriate oral health training and education is received by the care team members conducting the exam.

2. Determine best course of treatment for individual

a. The network designates care team member(s) to review the risk assessment and the oral exam with the individual[57]
b. The network develops a set of standardized criteria to determine the course of treatment that includes:
   i. Consideration for the answers on the risk assessment, findings from the oral exam, and individual preferences
   ii. Identification of which prevention activities can be provided in the primary care setting[58]

3. Provide necessary treatment – within primary care setting or referral to oral health provider

a. The network will determine who in the primary care setting is responsible for delivering preventive care[59]
   Training existing team members to provide the needed services (e.g., LPNs)
b. The networks provides prevention education and materials in the primary care setting, ideally by a trained health educator or care coordinator[60], that includes:
   i. Providing products that support oral hygiene if available (e.g., toothbrush, floss, etc.)[61]
   ii. Using the built in EMR tools that provide standardized education to the individual based on diagnosis

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[56] The oral exam can be conducted by anyone on the care team who has received the proper oral health training and education, but Medicaid only reimburses for the exam if it is conducted by a PCP, APRN, or PA for children under 3. Currently in discussions with DSS to reimburse for a broader age range

[57] Any member of the care team can review findings of the assessment and the exam with the individual, but as a general rule the severity of the condition should dictate the level of the person who interacts with the individual (e.g., if there is a concern about oral cancer findings should be shared by a primary care provider, if a referral is needed it can be shared by another member of the team)

[58] The following prevention activities are usually provided in the primary care setting: changes to medication to protect the saliva, teeth, and gums; Fluoride varnish application whenever applicable or prescription for supplemental fluoride for children not drinking fluoridated water (information on fluoridated water testing: http://oralhealth.uchc.edu/fluoridation.html); dietary counseling to protect teeth and gums, and to promote glycemic control for individuals with diabetes; oral hygiene education and instruction; therapy for tobacco, alcohol and drug addiction

[59] Preventive care provided in the primary care setting can be provided by any member of the care team with the exception of changing medications which needs to be done by the primary care provider

[60] If a health educator or care coordinator is not available other members of the care team can be trained to provide education

[61] The CTDHP can be a resource for this – will provide dental referral information and may issue free oral health products for Medicaid patients https://www.ctdhp.com/ or 1-855-CT-DENTAL

iii. Providing educational messages on prevention that can be provided by all members of the care team in the absence of a health educator or care coordinator
iv. Providing written materials such as a handout in the waiting room or an after visit summary as supplemental education

c. The network develops a process and protocols to make, manage, and close out referrals that include:
   i. Identifying a preferred dental network for referrals for individuals who do not have a usual source of dental care[62]
   ii. Coordinating to share the necessary health information with the individual's dental network which includes:
      1) Individual's problem list
      2) Current medication, allergies, and health conditions.
      3) Reason for the referral
      4) Confirmation that the individual is healthy enough to undergo routine dental procedures
   iii. Confirming the individual made an appointment with the dentist and the date of the appointment
   iv. Requesting a summary of the dentist's findings and treatment plan upon completion of the dental visit for inclusion in the individual's health record
   v. Developing technology solutions for sharing necessary information between primary care providers and dental providers[63]
   vi. Designating an individual to be responsible for tracking and coordinating referrals, confirming that the dental appoint was made, occurred, and the agreed upon material was shared between providers
   vii. Providing additional support services where/when possible (i.e.; transportation, interpretation, etc.)

4. Track oral health outcomes/improvement for decision support and population health management

a. The networks electronically captures the following items[64]:
   i. Risk assessment results
   ii. Oral risk assessment and screening results
   iii. Interventions received: referral order, preventions in clinic
   iv. Documentation of completed referral
b. The network monitors and reports on integration process that supports quality improvement and holding the primary care and dental partners accountable to the established agreements

[62] Medicaid patient and locations of safety-net facilities, contact CTDHP at 1-855-CT-DENTAL or https://www.ctdph.com.
[63] Networks should consider technologies such as direct messaging or secure messaging
[64] Networks should consider capturing data in a structured manner (i.e.; delimited fields vs free text) so data can easily be tracked for reporting purposes

ELECTIVE STANDARD 2:
ELECTRONIC CONSULTATION (E-consults)

Program Description and Objective:

Description: E-consults is a telehealth system in which Primary Care Providers (PCPs) consult with a specialist reviewer electronically via e-consult prior to referring an individual to a specialist for a face to face non-urgent care visit. This service can be made available to all individuals within the practice and for all specialty referrals, but may be more appropriate for certain types of referrals such as cardiology and dermatology. E-consult provides rapid access to expert consultation. This can improve the quality of primary care management, enhance the range of conditions that a primary care provider can effectively treat in primary care, and reduce avoidable delays and other barriers (e.g., transportation) to specialist consultation.

Objective: Improve timely access to specialists, improve PCP and specialist communication, and reduce downstream costs through avoiding unnecessary in-person specialist consultations.

High-Level Intervention Design:

1. **Identify individuals eligible for e-consult**
2. **Primary care provider places e-consult to specialist provider**
3. **Specialist determines if in person consult is needed or if additional information is needed to determine the need for in person consult**
4. **Specialist communicates outcome back to primary care provider**

1) Identify individuals eligible for e-consult

a) The network defines for which specialty they will do e-consults[65]

b) The network involves the individual in the decision to utilize an e-consult and will send e-consults for all individuals who require the service of the designated specialty and who assent to e-consult, with the exception of individuals with urgent conditions and those who have a pre-existing relationship with a specialist

2. Primary care provider places e-consult to specialist provider

a. The network designates with which specialty practice or specialty providers it will coordinate e-consults[66].

[65] Policy reports done in Connecticut by UCONN and Medicaid explored the use of e-consults for Cardiology, Dermatology, Gastroenterology, Neurology, Orthopedics and Urology (http://www.publichealth.uconn.edu/assets/econsults_ii_specialties.pdf; http://www.publichealth.uconn.edu/assets/econsults_cardiology.pdf)

[66] If the network does not have specialists in their network, they may want to consider establishing an e-consult relationship with a set of designated specialist providers who are distinct from the specialty providers who would do the face to face consult. This will promote neutral decision making on the part of the specialist by eliminating the financial incentive to suggest a face to face visit. If the specialists are within the same network, this will not be necessary.

b. In partnership with the specialty practice and/or providers, the network develops a standardized referral form that includes:
   i. Standard form text options to ensure important details are shared
   ii. Free text options to the opportunity for the primary care provider to share additional details of importance (Kim-Hwang JE, 2010)
   iii. The ability to attach images or other information that cannot be shared via form or free text

c) The network in partnership with the specialty practice develops a technology solution to push e-consults to the specialty practice and/or providers designated to do e-consults[67]

d) The network develops a process and protocol to send e-consults to the designated specialty practice and/or providers that includes:
   i) Identifying an individual in the primary care practice responsible for sending the e-consult to the specialty practice and/or providers
   ii) Setting a timeframe within which the e-consult should be sent post-primary care visit
   iii) Establishing a payment method for the e-consult service[68]

e) The specialty practice and/or provider develops a process and protocol to receive and review the e-consult that includes:
   i) Identifying a coordinator whose responsibility it is to receive and prepare the consult for review
   ii) Setting a timeframe within which the e-consult has to be reviewed once received by specialty practice

3) Specialist determines if in-person consult is needed or if additional information is needed to determine the need for in-person consult

The specialist triages the referral into one of three categories:
   i) The individual does not need a referral
   ii) The individual may need a referral but additional information is needed from the primary care provider (i.e.; additional history, additional tests run, etc.)
   iii) The individual needs an in-person visit

4) Specialist communicates outcome back to primary care provider

The network in collaboration with the specialty practice develops processes and protocols for primary care and individual notification of e-consult outcomes that include:
   i) Setting a timeframe within which the specialist notifies the primary care practice of e-consult result regardless of the outcome
   ii) Providing communication back to the primary care provider in the form of a consult note with information on how to handle the issue in the primary care setting when a consult is not needed
   iii) Identifying how the primary care provider will notify the individual that follow-up is needed and process for scheduling additional testing, if necessary

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[67] Solutions will vary based on available technology to both primary care providers and specialists. Range of solutions include: faxing, secure messaging, direct messaging, EMR based solution

[68] Currently Medicaid has limited reimbursement for e-consults. Additional exploration around expanded reimbursements is being investigated

iv) Identifying how the primary care practice will connect the individual to referral coordination services to schedule the visit, to confirm that a visit was scheduled and to ensure the necessary information from the specialist is shared with the primary care provider from the in-person consultation

ELECTIVE STANDARD 3:
COMPREHENSIVE MEDICATION MANAGEMENT

Program Description and Objective:

Description: The Comprehensive Medication Management (CMM) intervention will be an elective CCIP capability for patients with complex therapeutic needs who would benefit from a comprehensive personalized medication management plan. CMM is a system-level, person-centered process of care provided by credentialed pharmacists to optimize the complete drug therapy regimen for a patient's given medical condition, socio-economic conditions, and personal preferences. The CMM evidence-based model was approved by 11 national pharmacy organizations and is dependent upon pharmacists working collaboratively with physicians and other healthcare professionals to optimize medication use in accordance with evidence-based guidelines.[69] In the context of CCIP, the CMM intervention will be relevant for all patients who are experiencing difficulty managing their pharmacy regimen, who have complicated or multiple drug regimens, or who are not experiencing optimal therapeutic outcomes; this includes patients enrolled in CCIP with complex conditions and patients experiencing equity gaps.

Objective: To assure safe and appropriate medication use by engaging patients, caregivers/family members, prescribers, and other health care providers to improve medication-related health outcomes.

High-Level Intervention Design:

1. **Identify patients requiring comprehensive medication management**
2. **Pharmacist consults with patient/caregiver in coordination with PCP or comprehensive care team**
3. **Develop and implement a person-centered medication action plan**
4. **Follow-up and monitor the effectiveness of the medication action plan for the identified patient**

1. **Identification of patients requiring comprehensive medication management**
   a. The network defines criteria to identify patients with complex and intensive needs related to their medication regimen that would be conducive to pharmacist intervention[70];

[69] Joint Commission of Pharmacy Practitioners. *Pharmacists' Patient Care Process.* May 29, 2014. https://www.accp.com/docs/positions/misc/JCPP_Pharmacists_Patient_Care_Process.pdf

[70] Characteristics of patients with these needs could include patients with: multiple chronic conditions, complicated or multiple medication regimens, failure to achieve treatment goals, high risk for adverse reactions, preventable utilizations due to difficulty managing medication regimens (e.g. hospital admissions, readmissions,

b. The network develops a process for the responsible professional and/or care team to assess patient medication management needs[71]

2. **Pharmacist consults with patient and, if applicable, caregiver in coordination with PCP or comprehensive care team**
   a. The Advanced Network or FQHC selects a pharmacist integration model that aligns with their current network needs/current state.[72]
      i. Regardless of the model, the pharmacist should have direct care experience and pharmacist credentials are reviewed[73] [74]
      ii. The pharmacist will be trained to access the patient's EHR and comprehensive care plan, and any network-specific workflows, as needed.
   b. The pharmacist conducts the initial patient consult in person[75].

3. **Develop and implement a person-centered medication action plan**
   a. The pharmacist develops an action plan during the initial patient consultation in partnership with the patient and/or caregivers[76]
   b. To develop the person-centered medication action plan the pharmacist will:
      i. Create a comprehensive list of all current medications the patient is taking including prescribed medications, nonprescription/over-the-counter medications, nutritional supplements, vitamins, and herbal products. Assess each medication for appropriateness,

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emergency department, urgent care, and/or physician office visits), health equity gaps, multiple providers, functional deficits (e.g. swallowing, vision, and mobility problems), and multiple care transitions

[71] This assessment should occur at the time of the person-centered assessment for patients who are part of the CCIP Complex Care population. Other patients in need of additional medication management who are not part of CCIP can be identified/referred by other members of the care team or through automated triggers based on EHR-programmed "alert" claims or EHR-based analytic reports. The assessment should include patient preferences and concerns.

[72] Possible models include: (1) pharmacist is a clinician staff member of the practice; (2) pharmacist is embedded in the practice site through a partnership between the practice and another entity (e.g., hospital, school of pharmacy, etc.); (3) regional model by which the pharmacist works for a health system and serves several practices in a geographic area; and (4) shared resource network model by which the pharmacist is contracted by a provider group, ACO, or payer to provide services to specific patients

[73] Pharmacist should have some experience in a direct patient care role, and training should occur at on-boarding with additional team based training as needed (i.e.; new team members join, protocols change, etc.) and annual validation of credentials.

[74] Networks should determine the appropriate credentials for CMM services. CT has addressed pharmacist competencies with a State regulation for Collaborative Drug Therapy Management (CDTM), which includes interdisciplinary, team-based, patient-centered care. It is recommended that networks adopt the CDTM competencies language as minimum credentials for pharmacists providing CMM services. The CDTM regulation can be found here: http://www.healthreform.ct.gov/ohri/lib/ohri/work_groups/practice_transformation/reference_library_/ct_cdtm_regs_2012.pdf.

[75] For patients participating in the CCIP Complex Care program, this consult should occur in conjunction with the initial comprehensive care team person-centered assessment and/or care planning meeting, while other patients should schedule a consult with the pharmacist within a specified timeframe post-identification of the need for CMM. Once a patient is making good progress toward meeting the goals of a medication action plan, or for less complex patients, telehealth or telephonic, or other touch points may be advisable.

[76] In the CMM process every patient receives an action plan regardless of whether or not it is requested by the patient/caregiver.

efficacy, safety, and adherence/ease of administration given a patient's medical condition and co-morbidities.

ii. This assessment will be person-centered and also take into account the compatibility of medication with the individual's cultural traditions, personal preferences and values, home or family situation, social circumstances, age, functional deficits, health literacy, medication experiences and concerns, lifestyle, and financial concerns including affordability of medications compared to other regimens that achieve the same medical goals.

c. The person-centered medication action plan includes:
   i. An updated and reconciled medication list with information about medication use, allergies, and immunizations.
   ii. Education and self-management training to engage patients and their caregivers on better techniques to achieve self-management goals and adhere to the medication regimen.
   iii. The patient's treatment goals and pharmacist's actionable recommendations for avoiding medication errors and resolving inappropriate medication selection, omissions, duplications, sub-therapeutic or excessive dosages, drug interactions, adverse reactions and side effects, adherence problems, health literacy challenges, and regimens that are costly for the patient and/or health care system; pharmacist's recommendations are communicated to patients, caregivers, primary care provider, and other health care providers as needed.
   iv. An outline of the duration of the CMM intervention; frequency of interactions between pharmacist and patient throughout the CMM intervention; and instructions on follow-up with the pharmacist, comprehensive care team, primary care team, and specialists as needed[77].
   v. Coordination of care, including the referral or transition of the patient to another health care professional.

d. The person-centered medication action plan becomes a part of the patient's medical record
   The network develops a process or protocol to make the person-centered medication plan accessible to all necessary care team members. The process or protocol will include:
   1) Identifying who needs to have access to the person-centered medication action plan, which at a minimum will include the pharmacist and primary care provider but which should also be guided by patient preference and the team needs assessment[78].
   2) Developing technological capabilities for specified individuals to have access to the person-centered medication action plan

4. Follow-up and monitor the effectiveness of the medication action plan for the identified patient.

a. Pharmacist monitors and evaluates the effectiveness of the care plan and modifies the plan in collaboration with other health care professionals and the patient or caregiver as needed. This process includes the continuous monitoring and evaluation of:
   i. Medication appropriateness, effectiveness, and safety and patient adherence through available health data, biometric test results, and patient/caregiver/primary care provider feedback.
   ii. Clinical endpoints that contribute to the patient's overall health.
   iii. Outcomes of care, including progress toward or the achievement of goals of therapy.

[77] Patient with more complex needs may require more frequent follow-up with the pharmacist and care teams. The plan should identify the format for touch points, which should be guided by patient preference and the team needs assessment. Some formats include in-person, telephonic, and other telehealth mediums.

[78] If the patient has a comprehensive care team or is working with a Community Health Worker, those individuals should also have access.

b. Schedule follow-up care as needed to achieve goals of therapy.

The pharmacist and care team initiate follow-up care processes to schedule touchpoints with the patient and/or caregiver as outlined in the person-centered medication action plan[79]

1) The pharmacist participates in the comprehensive care team meetings if the patient is also participating in the CCIP complex patient intervention.
2) The pharmacist and care team define a process to monitor and revise the person-centered medication action plan as necessary after follow up visits with the care team.

[79] Other care team members who are part of the implementation plan are identified through the consultation process. The touch points should align with those identified in the person-centered medication action plan for those patients who are participating in the CCIP complex care management intervention.

Appendix C: Community & Clinical Integration Program – Community Health Collaboratives

COMMUNITY HEALTH COLLABORATIVES

Program Context, Description, and Objective:

Context: One of the core drivers of better healthcare outcomes in Connecticut's SIM Community and Clinical Integration Program initiative is the integration of healthcare delivery with community resources. Such resources are a means to address socio-economic factors that affect the ability to achieve good outcomes. Currently, stakeholders report a lack of integration and coordination across care settings—too few patients are connected to community resources, especially those with complex conditions or who are experiencing equity gaps. Because many community service providers are resource-, capacity-, and geographically-constrained, there is concern that having multiple networks seeking partnerships with community resources using different processes and protocols will lead to complexity and confusion among the clinical and community participants resulting in an adverse impact on consumer health outcomes. The development of community-wide consensus protocols or standards for coordination should improve efficient coordination and more effective support for complex patients and care transitions.

Many SIM states have successfully initiated this integration process by establishing systems of shared governance for community resources (Samuelson, 2015). For the purposes of integrating social support services into clinical care for Connecticut's CCIP initiative, the PTTF has recommended a similar approach of convening community stakeholders to establish local community health collaboratives.

A survey of the existing health and healthcare related collaborative structures will be undertaken so that, where appropriate, our approach can mobilize existing partnerships and resources. For example, there are collaboratives in Connecticut that are comprised of diverse stakeholder groups focused on supporting more effective care transitions and reduced readmissions. Other groups have emerged in response to the hospital's Community Health Needs Assessments and Community Benefit requirements for tax-exempt hospitals.[80] Advanced Networks and FQHCs that are operating in the local community will be strongly encouraged to participate, whether or not they are participating in MQISSP and CCIP.

Collaboration on the coordination of healthcare and community resources may provide the opportunity to establish the foundation for the population health strategies proposed in our model test grant including Prevention Service Centers and Health Enhancement Communities. Accordingly, the process for developing community health collaboratives may be undertaken in partnership with DPH and in collaboration with state health government stakeholders such as the Departments of Social Services, Mental Health and Addiction Services, Education, and Children and Families; local municipal leadership and health departments; private foundations; and other "Potential Partners" identified for specific focus areas in DPH's SHIP (footnote). The Collaboratives should also include Local Mental Health Authorities,

[80] http://www.irs.gov/Charities-&-Non-Profits/Charitable-Organizations/Hospitals-and-Community-Benefit-Interim-Report

housing and food assistance providers, community pharmacies, and other members of the non-profit and faith communities.

The responsibility for identifying and/or convening the collaboratives may be placed with the vendor responsible for providing technical assistance to participating entities in the CCIP program. The SIM PMO will include the responsibilities as well as the experience and skills required for this role, which might include experience coordinating healthcare, consumer, and community organizations and experience facilitating diverse groups of stakeholders to develop consensus-based solutions. While this convening responsibility may initially reside with the transformation vendor, we envision that the responsibilities to maintain the community health collaboratives will be transitioned to community leaders according to an agreed upon transfer plan.

Description: Establish consensus protocols to better standardize the linkage to and provision of socio-economic services related to the health needs of patients and care transition coordination among community participants. This system of shared decision-making helps further the integration of community services with healthcare services and may prepare communities for the next stage of shared accountability under population health related SIM initiatives. The community consensus guidelines will impact patients with complex conditions and health equity gaps, who are disproportionately in need of better coordination with community resources.

Objective: To improve healthcare outcomes by facilitating efficient coordination between primary care and other healthcare providers with community resources capable of addressing the socio-economic conditions that contribute to poor population health and healthcare outcomes.

High-Level Shared Community Health Board Collaborative Development Process:

1. **Planning Strategy**
2. **Identify and convene stakeholders impacted by the Community Health Collaborative model in defined area(s)**
3. **Develop standardized protocols and processes for network linkages to shared services**
4. **Implement long-term assessment and improvement process**

Detailed Community Health Board Collaborative Design Standards for Technical Assistance Vendor:

1. **Planning Strategy**

   The transformation vendor develops a planning strategy that ensures the Community Health Collaborative process is unbiased, inclusive of relevant stakeholders, and person-centered in its vision and goals. Strategy includes the following:

   i. Conflict of interest policies
   ii. Plans and timelines for regular meetings including for the transfer of convening responsibilities to a local board
   iii. Goals and objectives

2. **Identify and convene stakeholders impacted by Community Health Collaborative model in defined service area(s)**

   a. The vendor convenes healthcare and community stakeholders who are representative of the designated service area. Representative stakeholders at a minimum include:

   i. Social services providers reflective of the socio-economic and health needs of the patient populations being served, informed by the root cause analyses conducted for health care disparities and complex patients[81]
   ii. Local government agencies with health focused missions (e.g.; local health department, municipal leadership)
   iii. Healthcare providers from across the continuum of care (i.e., hospitals, LTSS, primary care practices, VNA/home health, FQHCs, specialists, behavioral health and dental providers, pharmacists, etc.)
   iv. United Way (2-1-1)[82]
   v. Consumers representative of the service area familiar with the target social, environmental and healthcare needs
b. The Community Health Collaborative will also work with state health government stakeholders, including the Department of Public Health and the SIM Project Management Office, and other state entities.
c. The vendor establishes a schedule for meetings that are open to the public

3. Develop standardized protocols and processes for network linkages to shared services

a. The Community Health Collaborative defines shared services and community linkages according to the local needs of the networks[83] and takes into consideration state population health needs, goals and strategies.
b. The Community Health Collaborative identifies operational areas appropriate for standardization working with networks to identify local needs[84]
c. The Community Health Collaborative develops protocols and processes that reflect the needs, resources, and capabilities of the local community in delivering integrated, person-centered care as follows:[85]
   i. Solicits input from patients and consumers to ensure the needs of the community are reflected[86]
   ii. Considers the capacity and capabilities of the healthcare and social service providers in the community[87]

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[81] Relevant socio-economic domains include, but are not limited to housing, nutrition, employment/vocational assistance, education, transportation, and legal assistance

[82] United Way representation will be required to participate due to the central role they play statewide to catalogue social service resources and access to data on the community's needs through the 2-1-1 program

[83] Shared services and community linkages include services where multiple networks call on a limited community resource.

[84] The Community Health Collaborative may assist networks with their needs assessments and help to aggregate data and analysis within available resources.

[85] Protocols to be standardized will be dependent on service area and community but may include: public awareness, education, and communication of the availability of community services; clinical processes for connecting individuals to community services (e.g. standardized transition checklist); and management of referrals and systems for verifying follow-up appointments.

[86] This includes ensuring that communications around processes for accessing needed services are culturally and linguistically appropriate.

[87] Because technology systems, methods of communication, and capacity to handle increased administrative tasks will vary across Connecticut, the community collaborative must strive to develop processes and protocols that reflect the capabilities of all participating community and healthcare providers in order to ensure the feasibility of the proposed standardized processes.

iii. Builds upon existing community health initiatives, partnerships and resources.

d. The Community Health Collaborative develops an implementation plan and process for proposed standardized processes and protocols across the networks and community partners

4. Implement long-term assessment and improvement process -

a. The Community Health Collaborative transitions convening responsibilities to a board of local stakeholders pursuant to agreed-upon plan
b. The transition plan and goals & objectives take into consideration, to the extent practicable, the SIM Population Health Plan including recommendations Health Enhancement Communities and Prevention Service Centers.
c. The Community Health Collaborative holds regular meetings and forums to collect concerns and feedback on potential improvements
d. Within available resources, the Community Health Collaborative incorporates a data collection and analytics function to determine the impact of these new protocols

   Analytics will compare health outcomes and utilization compared to a relevant baseline or comparison group in coordination with the SIM PMO

e. The Community Health Collaborative will update and modify these protocols over time given the results of the analytics and the feedback from collaborative participants.

Appendix D: Definitions

Community Health Worker: A frontline public health worker who is a trusted member of the community or has an excellent understanding of the community served. This trusting relationship allows the worker to serve as a link between health/social services and the community to help people access services and be sure that services are offered in the person's language and respectful of their cultural beliefs.

Community Linkages: Standardized processes for the seamless coordination, communication, and integration of a community of clinical health service providers with social services and supports to address the range of healthcare and socio-economic patient needs that contribute to health outcomes.

Complex Needs Patients: Individuals who have or are at risk for multiple complex health conditions, multiple detrimental social determinants of health, or a combination of both that contribute to preventable service utilization and poorer overall healthcare management that negatively impacts the individual's overall health status.

Comprehensive Behavioral Health Assessment: An assessment that screens for behavioral health (mental health) needs, substance abuse, and trauma and is delivered by a licensed clinical professional.

High Needs Patient: Individuals whose complex medical conditions are often compounded by physical, behavioral, environmental, oral health, or socioeconomic factors that are not well managed by the current healthcare system. As a result these individuals have frequent ER visits, hospital admissions or re-admissions due to unresolved, often preventable complications that drive up healthcare costs and result in poor patient outcomes.

Individualized Care Plan: A written personalized care plan which, under the person-centered assessment process, details an individual's integrated health and social care needs.

Medicaid Health Home: An optional Medicaid state plan benefit for states to establish Health Homes to coordinate care for people with Medicaid who have chronic conditions…CMS expects states health home providers to operate under a "whole-person" philosophy. Health home providers will integrate and coordinate all primary, acute, behavioral health, and long-term services and supports to treat the whole person (Medicaid, 2015).

Natural Supports: Can include but is not limited to family, clergy, friends and neighbors.

Patients Experiencing Equity Gaps: Individuals belonging to a sub-population experiencing poorer health outcomes in a specific clinical area (e.g., diabetes).

Patients with Unidentified Behavioral Health Needs: Any individual with a previously unidentified behavioral health need including mental health, substance abuse, or history of trauma.

Peer Support Specialist: A person who uses his or her own life experiences to provide counseling and support services to an individual.

Person-Centered: 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 process of shared-decision making to make informed decisions about their care plan and treatment. The individual identifies their natural supports, which may include but is not limited to family, clergy, friends and neighbors and chooses whether to involve them in their medical care planning.

Person-Centered Assessment: An assessment that will evaluate the person's past and current needs while considering the individual's cultural traditions, personal preferences and values, family situations, social circumstances and lifestyle.

Person-Centered Care Coordination Plan: A written plan used by the comprehensive care team that is developed with consideration for the individual's cultural traditions, personal preferences and values, family situations, social circumstances and lifestyles as well as their strengths.

Predictive Modeling: A set of criteria (e.g., diagnoses, demographics, procedures, service history, prescription drugs, etc.) that is used to predict potential of future risk for the types of healthcare outcomes that are trying to be prevented (e.g., unnecessary service utilization and costs).

Risk Stratification: The separation of a population into sub-populations based on a set of risk criteria. In this case the risk criteria being considered is around what makes an individual's healthcare issues complex, as defined by the Practice Transformation Taskforce (PTTF). The PTTF definition of complex is: Individuals who have either multiple complex medical conditions, multiple detrimental social determinants of health, or a combination of both that contribute to preventable service utilization and poorer overall healthcare management that ultimately negatively impacts the Individual's overall health status.

Shared Savings Program: A form of a value-based payment that offers incentives to provider entities to reduce healthcare spending for a defined patient population by offering physicians a percentage of the net savings realized as a result of their efforts. Savings are typically calculated as the difference between actual and expected expenditures and then shared between insurance payers and providers.

Social Determinant Risks

Value-based Insurance Design: Insurance plans that encourage patients to engage in healthy behavior, participate in their healthcare decisions, and make intelligent use of healthcare resources.

Value-based Payment Design: Form of payment that holds physicians accountable for the cost and quality of care they provide to patients. This differs from the more traditional fee for service payment method in which physicians are paid for volume of visits and services. The goal of value-based payments is to reduce inappropriate care and reward physicians, other healthcare professionals and organizations for delivering value to patients. Examples of value-based payments include shared savings programs (SSPs).

Appendix E: Practice Transformation Task Force Member Listing

- **Susan Adams**
  Masonicare
- **Lesley Bennett (Executive Team)**
  Stamford, CT
- **Mary Boudreau**
  CT Oral Health Initiative
- **Grace Damio**
  Hispanic Health Council
- **Leigh Dubnicka**
  United Healthcare
- **Garrett Fecteau (Executive Team)**
  Anthem
- **David Finn**
  Aetna
- **Heather Gates**
  Community Health Resources
- **M. Alex Geertsma**
  Community Health Center of Waterbury
- **Shirley Girouard**
  Branford, CT
- **Beth A. Greig**
  St. Francis Hospital and Medical Center
- **John Harper**
  ConnectiCare
- **Abigail Kelly**
  Chrysalis Center of CT
- **Edmund Kim**
  Family Medicine Center at Asylum Hill
- **Anne Klee**
  VA Connecticut Healthcare System
- **Ken Lalime**
  Healthy CT
- **Alta Lash**
  United Connecticut Action for Neighborhoods
- **Kate McEvoy**
  Department of Social Services, Medicaid
- **Rebecca Mizrachi**
  Norwalk Community Health Center
- **Douglas Olson**
  Norwalk Community Health Center
- **Nydia Rios-Benitez**
  Dept. of Mental Health & Addiction Services
- **Rowena Rosenblum-Bergmans**
  Western Connecticut Health Network
- **H. Andrew Selinger**
  ProHealth Physicians
- **Eileen Smith**
  Soundview Medical Associates
- **Anita Soutier**
  Cigna
- **Elsa Stone (Executive Team)**
  Pediatrics Plus
- **Randy Trowbridge**
  Team Rehab
- **Jesse White-Frese**
  CT Assoc. of School Based Health Centers

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