

COMPREHENSIVE CARE MANAGEMENT

FOCUS POPULATION: INDIVIDUALS WITH COMPLEX NEEDS

Developed under guidance from the Practice Transformation Taskforce (PTTF) as part of the Connecticut State Innovation Model Initiative

Complex Patient Definition: 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.

Program Description and Objective:

Description: Complex care management is a person-centered process for providing care and support to individuals with complex 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 intervention standards for individuals with complex health needs are intended to complement 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 comprehensive care team that includes community-based service and support providers. The additional components of the individual's care plan and the services provided will be communicated directly back to the primary care team and 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 by the transformation vendor at the start of the program.

Objective: The short-term objective is to comprehensively address identified barriers to care and healthy living and engage the individual directly in their own self-care. In the long-term, the objective is to provide the individual with the appropriate resources and skills to improve their feelings of empowerment to do self-care management with ongoing primary care team support. This will be accomplished by providing person-centered comprehensive care management, education and self-management support services, skills training, and connections to community and social support services.

High-Level Program Design:

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 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.

1. Identify individuals with complex needs
2. Establish a comprehensive care team
3. Connect individuals to the comprehensive care team
4. Conduct person-centered assessment
5. Develop a comprehensive care plan
6. Execute and monitor the comprehensive care plan
7. Identify when individual is ready to transition to self-directed care maintenance
8. Monitor individuals to reconnect to comprehensive care team when needed
9. Evaluate the effectiveness of the intervention

1. Identify complex individuals

- The network identifies complex individuals who will benefit from the support of a comprehensive care team by using analytics to develop a risk stratification¹ methodology that takes into consideration utilization data (claims-based) and clinical, behavioral, and social determinant risks (EMR-based)²
- The network conducts a root cause analysis for the complex individual sub-population and identifies and implements at least one additional network capability to supplement the comprehensive care team intervention.
- The root cause analysis utilizes:
 - Relevant clinical data
 - Input from the complex individual sub-population³

2. The network establishes a comprehensive care team

- The network develops a comprehensive care team capability that fulfills several functions⁴ including:
 - Care management focused on engaging patients in better self-care⁵
 - Clinically focused care coordination
 - Community focused care coordination to link individuals to needed social services and supports as well as culturally and linguistically appropriate self-care management education.
 - The capability to add a Community Health Worker⁶ on the comprehensive care team to fulfill community focused functions.
 - Oversight and management of the comprehensive care team

¹ See Appendix E for definition

² See Appendix F for examples of the type of criteria used in other models

³ 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

⁴ The networks will have the freedom to determine which care team members best fulfill these functions with the exception of the CHW, and can utilize licensed or unlicensed individuals to fulfill these roles

⁵ Models have demonstrated that embedding a designated care manager for complex patients into the care team to coordinate with the primary care team, practice personnel, and additional members of the team responsible for community and social services generates good results and is recommended where possible

⁶ See Appendix E for definition

- The network designates a lead care manager with responsibility for facilitating an effective comprehensive care team process and ensuring the achievement of the individual’s lifestyle and clinical outcome goals.
- The network provides timely access to or has a comprehensive care team member who is a licensed behavioral health specialist capable of conducting a comprehensive behavioral health assessment⁷
- The network adds comprehensive care team members outside of the above core functions (i.e.; dietitians, pharmacists, etc.) on an as needed basis depending on the needs identified in the person-centered assessment
- The network determines the best strategy for integrating additional comprehensive care team members. Options include:
 - Contracted or employed staff that reside within each primary care practice or in one or more hubs that support multiple practices
 - Coordination protocols for integrating affiliated clinical staff (e.g., specialists)
 - Contracted support from community organizations (e.g., CHW staff)
 - Collaborative agreements with clinical partners (e.g., home care)⁸
- The network establishes the appropriate case load (patient to team ratio) for comprehensive care teams⁹
- The network establishes training protocols on:
 - Identifying values, principles and goals of the comprehensive care team intervention
 - Redesigning the primary care workflow to integrate the comprehensive care team work processes
 - Orienting the primary care team to the roles and responsibilities of the additional members that form the comprehensive care team¹⁰
 - Basic behavioral health training appropriate for all comprehensive community care team members
 - Delivering culturally and linguistically appropriate services consistent with Department of Health and Human Services, Office of Minority Health, CLAS standards
- The network develops and administers CHW training protocols or ensures that CHWs have otherwise received such training:
 - Person-centered assessment
 - Outreach methods and strategies
 - Effective communication methods
 - Health education for behavior change
 - Methods for supporting, advocating and coordinating care for individuals

⁷ See Appendix E for definition

⁸ Likely the only member of the comprehensive care team for which contracting would be an option is the community health worker

⁹ Optimal ratios should be determined by the network based on local needs

¹⁰ The PTF expressed that the network and its practices understanding of a Community Health Worker role is of particular importance as unlike other members of the care team their primary role is to support and coordinate care for the individual in the community, posing a significant departure from how care is more commonly delivered today

- Public health concepts and approaches¹¹
- Community capacity building (i.e.; improving ability for communities to care for themselves) (Boston, 2007)
- Safety training geared toward maintaining safety in the home
- The network ensures training is provided:
 - To all primary care team members that are part of or engage with the comprehensive care team
 - On an annual basis to incorporate new concepts and guidelines and reinforce initial training

3. Connect individuals to a comprehensive care team

- The network implements a process to connect individuals to a complex care team. Options for engagement with the individual include:
 - During the primary care visit
 - During an ED visit or inpatient hospital stay¹²
 - Pro-actively reaching out to the individual identified through analytics or registry data¹³

4. Conduct person-centered assessment¹⁴

- To understand the historical and current clinical, social and behavioral needs of the individual to inform the person-centered care coordination plan, the network conducts a person-centered needs assessment that includes¹⁵:
 - Preferred language
 - Family/social/cultural characteristics
 - Assessment of health literacy
 - Social determinant risks
 - Personal preferences, values, needs, and strengths
 - Assessment of behavioral health needs, inclusive of mental health, substance abuse, and trauma
 - Reproductive health needs
 - The primary and secondary clinical diagnoses that are most challenging for the individual to manage
- Network defines process and protocols for the comprehensive care team to conduct the person-centered needs assessment that defines:
 - Where the person-centered needs assessment takes place¹⁶

¹¹ 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.

¹² Networks could consider utilizing an ED/Inpatient technology that alerts the comprehensive care team upon admission and discharge of eligible individuals

¹³ 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)

¹⁴ See Appendix E for definition

¹⁵ See Appendix B for an example of a needs assessment

¹⁶ The PTF believes this should be determined by the individual

- The timeframe within which the person-centered needs assessment is completed post-identification of individual need

5. Develop a comprehensive care plan¹⁷

- The comprehensive care team and the individual and their natural supports¹⁸ collaborate to develop a comprehensive care plan¹⁹ that reflects the person-centered needs assessment and includes the following features:
 - Reflects the individual's values, preferences, clinical outcome goals, and lifestyle goals
 - Establishes behavioral health goals to address existing mental health, substance abuse, or trauma needs
 - Establishes social health goals to address social determinant risk factors
- The network defines a process and protocol for the comprehensive care team to create the comprehensive care plan including location and timeframe for completion

6. Execute and monitor comprehensive care plan

- The network establishes protocols for regular comprehensive care team meetings that establish:
 - Who is required to attend²⁰
 - The frequency of the meetings
 - The format of the meetings (i.e.; via conference call, in person, etc.)
 - A standardized reporting form on the individual's progress and risks
- The network establishes protocols for monitoring individual progress on the comprehensive care plan that includes:
 - Establishing key touch points for monitoring and readjusting of the comprehensive care plan, as necessary
 - Establishing who from the comprehensive care team will be involved in the touch points
 - Developing a standardized progress note that documents key information obtained during the touch points
- The network modifies its process for exchanging health information across care settings to accommodate the role and functions of the comprehensive care team²¹
- 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 transitions²²

¹⁷ See Appendix E for definition

¹⁸ Natural supports include but are not limited to, family, clergy, friends, and neighbors

¹⁹ See Appendix F for an examples of person-centered care coordination plans

²⁰ Best practice suggests all members of the comprehensive care team and relevant primary care team members

²¹ This will include 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

²² SIM may support technology solution capable of alerting to admissions and discharge in the future. Protocols involving care transitions should focus on any updates/correction in the care plan as a result of the health event, in particular any updates in living conditions or personal preferences of the patient and caregivers, to ensure ongoing support in pursuit of patient goals. Where possible treatment should be provided in the setting of the patient's

- The network establishes a process and protocols for connecting individuals to needed community services (i.e.; social support services) which include:
 - See: *Community Consensus Linkages Process and Guidelines* in Appendix C

7. Identify when the individual is ready to transition to self-directed care maintenance and primary care team support

- The comprehensive care team collaborates with the individual to assess readiness to independently self-manage and transition to routine primary care team support²³
- If desired by the individual, the network provides transitional support by connecting them to a Peer Support resource

8. Monitor individuals to reconnect to comprehensive community care team when needed

- The network establishes a mechanism to:
 - monitor and periodically re-assess transitioned individuals
 - notify the comprehensive care team when the individual has a change of condition or circumstances that require a reconnection to the comprehensive care team²⁴

9. Evaluate the effectiveness of the intervention

- The network demonstrates that the comprehensive care team is improving health care outcomes and care experience for complex individuals by:
 - Tracking aggregate clinical outcome, individual care experience, and utilization measures that are relevant to the focus population's needs (i.e.; complex individuals)²⁵
 - Achieving improved performance on identified measures
- Identify opportunities for quality process improvement. This will require:
 - Defining process and outcome measures specific to the comprehensive care team intervention
 - Establishing a method to share performance²⁶ data regularly with comprehensive care team members and other relevant care providers to identify opportunities for improvement

choosing, often in the home, and providers should focus on increased communication with patients, including visits, in 24-48 hours post-transition with additional communication with providers post-transition.

²³ See Appendix F for sample tool

²⁴ The network could consider utilizing a ED/Inpatient admission/discharge alert technology for monitoring

²⁵ 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

²⁶ 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