Standard 1: Comprehensive Care Management

Identifying and managing patients with complex healthcare needs is key to meeting quality and cost targets. Comprehensive care management is most effective when the primary care team uses additional staff to assess a cohort of identified patients, develop a care plan, and follow through to ensure the right care is provided.

This Standard identifies key components of an effective Comprehensive Care Management strategy. In order to achieve the Standard, your network must achieve the goals and demonstrate improvement on the process measures, as detailed below.

Goals:

Your network has a **clear, detailed, documented policy** for identifying patients with complex needs, developing individualized care plans, and connecting patients with a comprehensive care management team that effectively executes and monitors the care plans.

85% of the practices in your network have fully implemented the policy.

Process Measures:

1. Increase use of Person Centered Assessments (PCAs) with complex patients
2. Increase identification of Social Determinants of Health (SDOH) needs among high risk patients
3. Increase use of Community Health Workers (CHWs) for navigation and linkage
4. Increase use of Comprehensive Care Team

Outcome Measures:

1. Decrease hospital admissions, readmissions, and ED visits

Key Elements of Comprehensive Care Management

Identify individuals with complex health care needs

1. Use analytics-based risk stratification to identify patients with current and rising risk based on:
   a. Claims-based utilization data
   b. EMR-based clinical, behavioral, and SDOH data
   c. Provider Referral
   d. External data, if possible (e.g., Homeless Management Information System)
2. Implement electronic alerts to inform medical home team of identified patients

Conduct Person Centered Assessment (PCA)

1. Conduct a Person Centered Assessment (PCA) with identified patients. Include:
   a. Preferred language (spoken and written)
   b. Family/social/cultural characteristics including sources of support
   c. Assessment of health literacy
   d. Social determinant risks
   e. Personal preferences, values, needs, and strengths
   f. Behavioral health needs, including depression and substance use
   g. Functional assessment
   h. Reproductive health needs
   i. Primary and secondary clinical diagnoses that are most challenging for the individual to manage
2. Establish a policy:
   a. **Where** PCA occurs
   b. **When** PCA is completed
   c. **Who** conducts PCA

Develop Individualized Care Plan (ICP)

1. Develop Individualized Care Plan (ICP) through collaboration with patient and their natural supports. The ICP should:
   a. Reflect the individual's values, preferences, clinical outcome goals, and lifestyle goals
   b. Establish physical and behavioral clinical care goals
   c. Establish social health goals
   d. Identify referrals necessary to address goals and a plan for linkage and coordination
2. Establish a policy:
   a. **Where** ICP is developed
   b. **When** ICP is developed
   c. **Who** develops ICP
   d. **How often** ICP is updated

Establish Comprehensive Care Team

1. Develop a comprehensive care team capability that specifically addresses the individual needs of the patient in accordance with the ICP. The Care Team should:
   a. Designate a lead care coordinator
   b. Add a Community Health Worker to the team for individuals with identified need for navigation, coaching, or linkage to community services and supports.
   c. Add a Licensed Behavioral Health Specialist (whether community based or part of the AN/FQHC) to the team for individuals with identified behavioral health needs.
   d. Adding team members specific to other identified needs (e.g., nutrition, medication management) is strongly encouraged.
2. Establish a policy:
   a. **When** individual is connected to Care Team (e.g., during primary care or ED visit)

b. **Who** connects individual to Care Team
c. **Who** is part of the Care Team
d. **How** additional Care Team members are integrated (i.e. direct employment, contractual, collaborative)
e. **How many** patients Care Team can manage (case load)

3. Establish annual training to successfully integrate and sustain comprehensive care teams.
   a. Orient primary care team to the roles and responsibilities of additional care team members
   b. Identify values, principles and goals of the comprehensive care team intervention
   c. Provide training to all care team members in:
      (1) Basic behavioral health integration
      (2) Motivational interviewing (required for the care coordinator, recommended for others)
      (3) 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
   d. Administer CHW training or ensure CHWs have training in:
      (1) Person-centered assessment
      (2) Outreach methods and strategies
      (3) Effective communication methods
      (4) Motivational interviewing
      (5) Health education for behavior change
      (6) Methods for supporting, advocating and coordinating care for individuals
      (7) Public health concepts and approaches
      (8) Community capacity building (i.e.; improving ability for communities to care for themselves)
      (9) Maintaining safety in the home
      (10) Basic behavioral health training to enable recognition of behavioral health needs

Execute and Monitor ICP

1. Hold regular Comprehensive Care Team meetings
2. Monitor Individual Progress on ICP. Establish:
   a. Key touch points for monitoring and readjusting the ICP
   b. Who will be involved in key touch points
   c. Standard Progress Notes
   d. Patient plan to meet self-directed care management goals
3. Modify process for health information exchange to accommodate the role and functions of the comprehensive care team. Establish:
   a. **What** data is shared
   b. **When** data is shared
   c. **How** referrals are facilitated
4. Establish a technology solution to alert comprehensive care team when a patient is admitted or discharged from an ED, hospital, or other acute care facility.
5. Establish a process for accessing an up-to-date resource directory (such as United Way 211), connecting individuals to needed community resources tracking referrals, and tracking barriers to care, and providing facilitation to address such barriers.

Assess individual readiness to transition to self-directed care maintenance

1. Assess individual readiness to self-manage and transition to routine primary care team support
2. Connect individual to ongoing community supports such as a peer support resource, as needed

Monitor individual need to reconnect with Comprehensive Care Team

1. Monitor and periodically re-assess transitioned individuals (ideally every 6-12 months)

2. Notify the comprehensive care team when the individual has a change of condition or circumstances that require a reconnection to the comprehensive care team

Evaluate and improve the intervention

1. Demonstrate comprehensive care team effectiveness through:
   a. Aggregate clinical outcome, individual care experience, and utilization measures that are relevant to the focus population's needs (i.e.; complex individuals)
   b. Improved performance on identified measures
2. Identify Quality Improvement Process
   a. Define process and outcome measures specific to the comprehensive care team intervention
   b. Develop training modules for the care team, community supports, and patients/families

Standard 2: Health Equity Improvement Part 1

This Standard identifies key components of an effective Health Equity Improvement strategy. In order to achieve the Standard, your network must achieve the goals and demonstrate improvement on the process measures, as detailed below.

Goals:

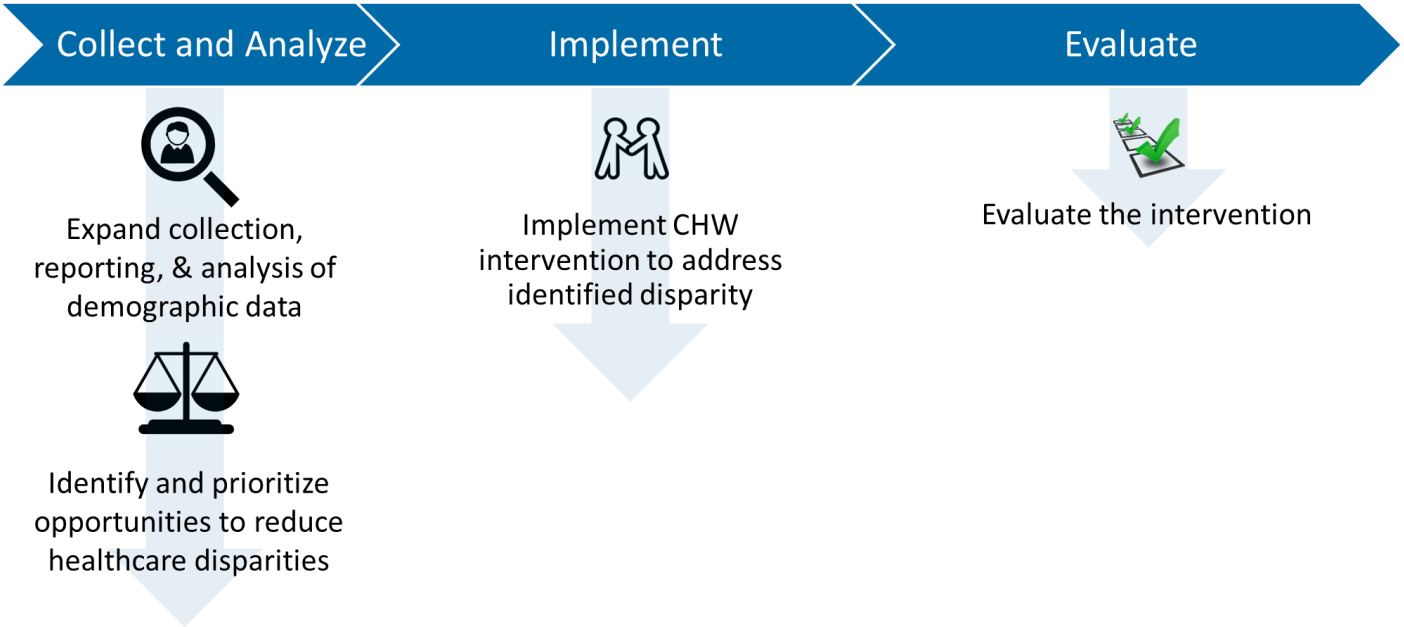
Your network has a **clear, documented policy and procedure** to collect granular race/ethnic data, analyze the data to identify disparities in care, and conduct root cause analyses to identify and implement interventions to address those disparities.

85% of the practices in your network have fully implemented the policy and procedure.

Process Measures:

5. Increased collection of CDC compliant race and ethnicity data documented in the EHR
6. Increased collection of sexual identification and gender identity data documented in the EHR
7. Increased collection of preferred language data documented in the EHR

Key Elements of Health Equity Improvement



Expand the collection, reporting, and analysis of standardized demographic data stratified by sub-populations

1. Collect race and ethnicity categories for all patients that go beyond the broad OMB categories. The selection of additional categories must:
    a. Draw from the recognized “Race & Ethnicity—CDC’’ code system in the PHIN Vocabulary Access and Distribution System (VADS) or a comparable alternative;
    b. Have the capacity to be aggregated to the broader OMB categories;
    c. Be representative of the population it serves based on (a) data (e.g., census tract data, surveys of the population) and; (b) input from community and consumer members
2. Collect information regarding sexual orientation and gender identity (SOGI) for all patients
3. Identify valid clinical and care experience performance measures to compare clinical performance between sub-populations. Such measures should:
    a. Maximize alignment with the CT SIM quality scorecard;
    b. Include the categories identified in 1 and 2above and preferred language;
    c. Address outcomes rather than process whenever possible;
    d. Meet generally applicable principles of reliability, validity, sampling and statistical methods
4. Analyze the identified clinical performance and care experience measures stratified by race/ethnicity, language, sexual orientation and gender identity, and geography/place of residence.
5. Establish methods of comparison between sub-populations by comparing measures internally against the network’s attributed population or to a benchmark.
6. Conduct 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

Identify and prioritize opportunities to reduce healthcare disparities

1. Document opportunities to reduce healthcare disparities identified through data analysis
2. Prioritize opportunities by engaging members of the sub-population.

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

1. Conduct a root cause analysis for the identified disparity and develop an intervention. To conduct the analysis, utilize:
    a. Relevant clinical data
    b. Input from the focus sub-population for whom a disparity was identified
2. Design a pilot intervention that will meet the needs/barriers identified in the root cause analysis
3. Involve members of the sub-population who are experiencing the identified disparity in the intervention design
4. Implement an intervention in at least five practices

Evaluate intervention

1. Demonstrate that the intervention is reducing the healthcare disparity identified by:
    a. Tracking aggregate clinical outcome and care experience measures aligned with the measures used to establish that a disparity existed
    b. Achieving improved performance on measures
    c. Sharing evaluation findings with the focus sub-population
2. Identify opportunities for quality and process improvement.

Standard 2: Health Equity Improvement Part 2

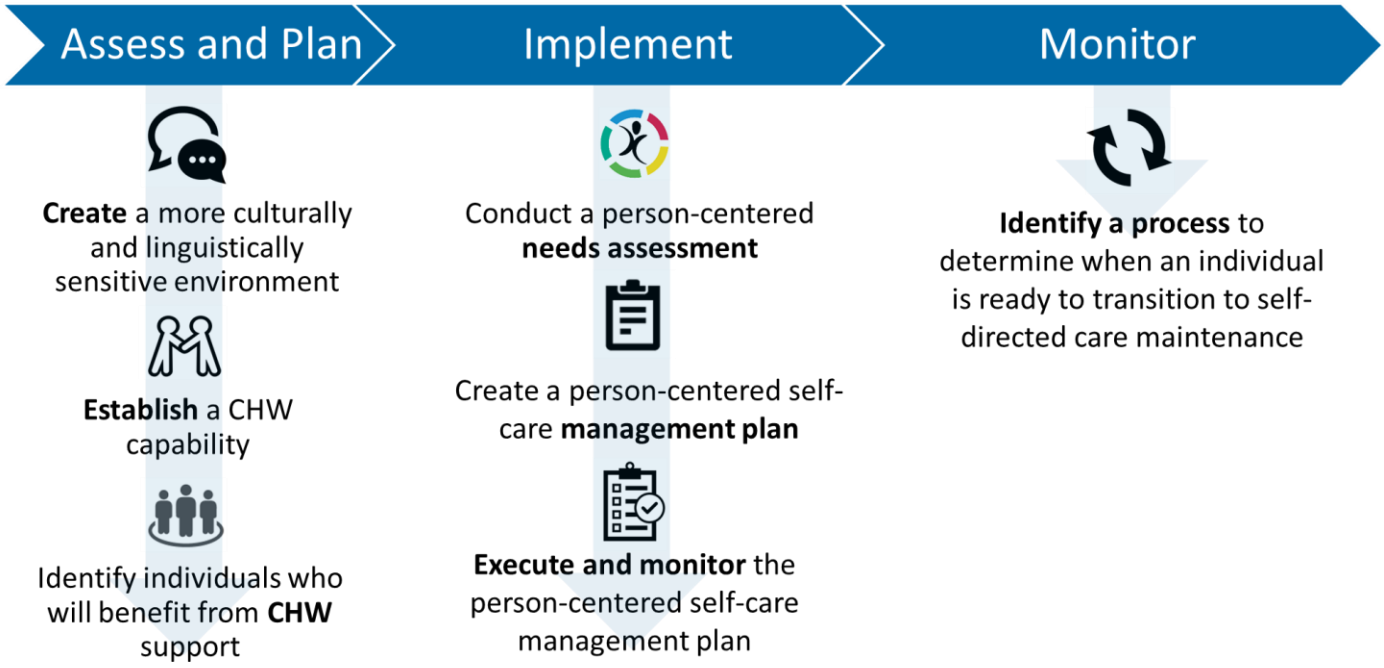
This Standard identifies key components of an effective Health Equity Improvement strategy. In order to achieve the Standard, your network must achieve the goals and demonstrate improvement on the process measures, as detailed below.

Goals:
Your network has a **clear, documented policy and procedure** for identifying individuals who would benefit from a Community Health Worker capability, implementing that capability, and identifying when individuals are ready to transition to self-directed care.

5 of your practices have fully implemented the CHW capability

Process Measures:
Process measures will be unique to the subpopulation and disparity identified for your intervention

Key Elements of Health Equity Improvement



Create a more culturally and linguistically sensitive environment

1. Provide culturally and linguistically appropriate services informed by the root-cause analysis including:
    i. Culturally informed and health literacy sensitive methods of patient engagement, treatment, support, and education
    ii. Interpretation/bilingual services
    iii. Printed educational materials

Establish a CHW capability

1. Incorporate Community Health Workers into target practices. Options include:
    i. Employ the CHWs within the practice
    ii. Employ the CHWs at one or more hubs in support of multiple practices
    iii. Contract with community organizations for CHW services
2. Determine how CHWs will be made available to individuals identified for the intervention
3. Establish appropriate supervision and case load for CHWs
4. Establish training for all care team members involved in the CHW intervention annually to:
    i. Identify values, principles, and goals of the CHW intervention
    ii. Redesign the primary care workflow
    iii. Orient the primary care team to the roles and responsibilities of the CHW
5. Ensure CHWs receive core competency and disease-specific training based on the intervention

Identify individuals who will benefit from CHW support

1. Establish criteria to determine who receives CHW support by assessing 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
2. Electronically alert the medical home team when individuals meet the criteria for a CHW intervention

Conduct a person-centered needs assessment

1. Conduct a person-centered needs assessment with individuals identified for the intervention that includes:
    i. Family/social/cultural characteristics
    ii. Behaviors affecting health
    iii. Assessment of health literacy
    iv. Social determinant risks
    v. Personal preferences and values
2. Establish a policy- **when, where, how, and by whom** the assessment is completed

Create a person-centered self-care management plan

1. The CHW, the individual, and their natural supports collaborate to develop a self-care management plan. The care plan should:
    i. Incorporate the individual's values, preferences and lifestyle goals

ii. Establish health behavior goals reflective of the individual's stage of change
iii. Establish social health goals reflective of identified needs/barriers
iv. Identify actions steps for each goal and establish a due date

2. Establish a policy- **when, where, how, and by whom** the plan is developed

Execute and monitor the self-care management plan

1. Hold regular care team meetings and establish key touchpoints with individuals to monitor progress on self-care management plans
2. Establish a Policy:
   a. **Who** attends meetings and **Who** is involved in key touchpoints
   b. **When** and **Where** meetings and key touchpoints are held
   c. **How** individual's progress and risks are tracked and reported in a standardized way
   d. **How** health information is exchanged across settings to accommodate CHW support
   e. **How** individuals are connected to needed community services (i.e. social support services)

Determine when an individual is ready to transition to self-directed maintenance

1. Develop criteria to evaluate when the individual has acquired the necessary education and self-care management skills to transition to self-directed maintenance that includes:
   a. Collaborating with the individual to assess their readiness to independently self-manage their care
   b. Assessing improvement on the relevant clinical outcomes
   c. Assessing achievement of individual identified care goals

Standard 3: Behavioral Health Integration

This Standard identifies key components of an effective Behavioral Health Integration strategy. In order to achieve the Standard, your network must achieve the goals and demonstrate improvement on the process measures, as detailed below.

Goals:

Your network has a **clear, detailed, documented policy** for identifying individuals with behavioral health needs, connecting those individuals with appropriate care, and tracking outcomes.

85% of the practices in your network have fully implemented the policy.

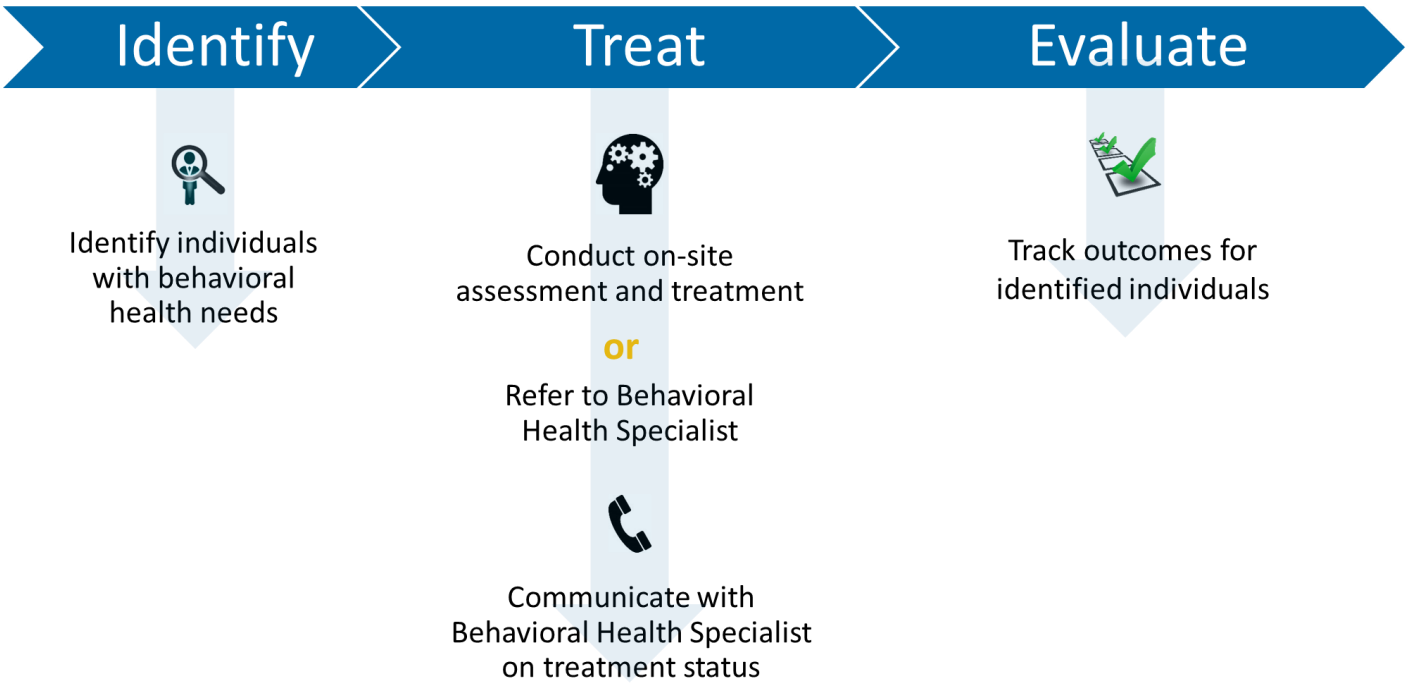
Process Measures:

8. Improved rate of depression screening
9. Improved rate of substance use screening
10. Improved rate of primary care follow-up for depression
11. Improved rate of primary care follow-up for substance use
12. Improved rate of Behavioral Health Specialist follow-up for depression
13. Improved rate of substance use specialist follow-up for substance use

Outcome Measure:

1. Increased rate of depression remission

Key Elements of Behavioral Health Integration



Identify individuals with behavioral health needs

3. Screen all patients for **depression** and **substance use** in the primary care setting
    a. Develop or use a screening tool that can be self-administered or administered by an individual who does not have a mental health degree. At a minimum, include the PHQ-9 for depression (may use PHQ-2 for initial screen) and a standardized and validated tool for substance abuse.
    b. Ensure there are support services to administer the tool for individuals with barriers to completing the screening tool on their own
    c. Utilize a trained behavioral health specialist on site or through referral (at least with masters level training) who conducts a more targeted follow-up assessment when necessary
    d. Conduct the behavioral health screening no less often than every two years
    e. Develop a process for identifying a re-screening at each routine visit
    f. Capture screening results in the EHR and make accessible to all relevant care team members

Address behavioral health needs

1. Conduct an assessment of needed behavioral health resources to support your practices
2. Establish the necessary relationships with behavioral health providers to meet your needs
3. If sufficient behavioral health services are not in network, execute an MOU with at least one behavioral health clinic and/or practice and develop processes and protocols for other behavioral health providers
4. Use a standardized set of criteria to determine whether or not the behavioral health condition can be addressed in the primary care setting by a primary care provider. Consider:
    a. Diagnosis/behavioral health condition
    b. Level of impairment/Severity of need
    c. Comfort level of the primary care team to manage the individual's needs
    d. Complexity of the required medication management
    e. Age of the individual
    f. Individual preference
    g. If the provider doing medication management for the individual has psychiatric medication management training
5. Educate individuals that screen positive for a behavioral health condition using available behavioral health resources regardless of the need for a referral
6. Ensure that primary care team members that provide behavioral healthcare have training that covers:
    a. Behavioral health promotion, detection, diagnosis, and referral for treatment
    b. How information will be exchanged and within what timeframe
    c. Defining a timeframe within which a referral should be completed
    d. Appropriate coding and billing
7. Ensure that all referrals are tracked and linkage to follow-up care is confirmed.

Communicate with Behavioral Health Specialist on treatment status

1. Develop process, protocol, and technology solutions for behavioral health provider to make the assessment and care plan available to the primary care team with appropriate consent
2. Ensure behavioral healthcare plan outlines treatment goals, including **when** follow up is required and **who** is responsible for follow up
3. Ensure 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

Track behavioral health outcomes/improvement for identified individuals

1. Utilize individual tracking tool to assess and document individual progress at one year and other intervals as determined by the provider
2. Develop processes and protocols for updating tracking tool that include:
    a. **Who** is responsible for updating
    b. **When** updates are to be made
    c. **How** treatment should be adjusted if not effective