

CORE STANDARD 1:
COMPREHENSIVE CARE MANAGEMENT (CCM)
FOCUS POPULATION: INDIVIDUALS WITH COMPLEX HEALTH CARE NEEDS

High-Level Intervention Design:

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

1) Identify individuals with complex health needs

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 takes into consideration utilization data (claims-based); clinical, behavioral, and social determinant data (EMR-based); and provider referral.

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) Reproductive health needs
 - viii) 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 collaborate to develop the individualized care plan that reflects the person-centered needs assessment and includes the following features:
 - i) Reflects the individual's values, preferences, clinical outcome goals, and lifestyle goals
 - ii) Establishes clinical care goals related to physical and behavioral health needs
 - iii) Establishes social health goals to address social determinant risks
 - iv) Identifies referrals necessary to address clinical care and social health goals and a plan for linkage and coordination
- b) The network defines a process and protocol for the creation of 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
- 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 conducting a comprehensive behavioral health assessment
 - iv) 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
- e) The network ensures that practices have a documented policy and procedure for integrating additional comprehensive care team members. Options include:
 - i) Contracted or employed staff that reside within each primary care practice or in one or more hubs that support multiple practices
 - ii) Coordination protocols for integrating affiliated clinical staff (e.g., specialists)
 - iii) Contracted support from community organizations (e.g., CHW staff)
 - iv) Collaborative agreements with clinical partners (e.g., home care)
- f) The network establishes the appropriate case load (patient to team ratio) for comprehensive care teams based on local needs
- g) The network establishes training protocols related to:

- i) Identifying values, principles and goals of the comprehensive care team intervention
- 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
 - 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
 - ii) The frequency of the meetings
 - iii) The format of the meetings (i.e.; via conference call, in person, etc.)
 - iv) A standardized reporting form on the individual's progress and risks
- b) The network establishes protocols for monitoring individual progress on the individualized care plan, **reporting adverse symptoms to the care team, supporting treatment adherence, and taking action when non-adherence occurs or symptoms worsen. The protocol** includes:
 - i) Establishing key touch points for monitoring and readjusting the individualized care plan, as necessary
 - ii) Establishing who from the comprehensive care team will be involved in the touch points
 - iii) Developing a standardized progress note that documents key information obtained during the touch points
 - 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 connecting individuals to needed community services (i.e.; social support services), 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
 - 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
- 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)
 - ii) Achieving improved performance on identified measures
 - b) The network identifies opportunities for quality process improvement. This will require:
 - i) Defining process and outcome measures specific to the comprehensive care team intervention
 - ii) Developing training modules for the care team, community supports, and patients/families
 - iii) Establishing a method to share performance 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
 - c) The network implements at least one additional network capability to support the comprehensive care team process.

CORE STANDARD 2:
HEALTH EQUITY IMPROVEMENT
PART 1: CONTINUOUS QUALITY IMPROVEMENT STANDARDS
FOCUS POPULATION: INDIVIDUALS EXPERIENCING EQUITY GAPS

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 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, Office of Management and Budget (OMB) race/ethnicity categories and preferred language in their EMR
 - iii) Are quantifiable and address outcomes rather than process whenever possible.
 - iv) Meet generally applicable principles of reliability, validity, sampling and statistical methods.
 - b) The network analyzes the identified clinical performance and care experience measures stratified by race/ethnicity, language, and other demographic markers such as sexual orientation and gender identity
 - c) 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
 - ii) Stratification by race/ethnicity is informed by the demographics of the population served by the network
 - d) **The network conducts a workforce analysis that includes analyzing the panel population in the service area, evaluating the ability of the workforce to meet the population's linguistic and cultural needs, and implementing a plan to address workforce gaps**
 - 2) Identify and prioritize opportunities to reduce healthcare disparities**
 - a) The network documents and makes available to the technical assistance vendor the results of the opportunities identified through data analysis
 - b) The network develops a process to prioritize opportunities. Prioritization considers:
 - Significance to individuals in the sub-population experiencing a disparity in care, which is evaluated through engaging members of the sub-population to prioritize opportunities
 - 3) Implement at least one intervention to address the identified disparity (see Part 2)**
 - a) The network conducts a root cause analysis for the disparity identified for intervention and develops an intervention informed by this analysis
 - b) The root cause analysis utilizes:

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

4) Evaluate whether the intervention was effective

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

PART 2: HEALTH EQUITY INTERVENTION PILOT

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 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 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**

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

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

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

- a) The CHW and the individual and their natural supports 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
 - 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
- 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

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
 - 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
- 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

- 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

**CORE STANDARD 3:
BEHAVIORAL HEALTH INTEGRATION**

FOCUS POPULATION: PATIENTS WITH UNIDENTIFIED BEHAVIORAL HEALTH NEEDS

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

- 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 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
- 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 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
- g) The screening tool results are captured in the EMR and made accessible to all relevant care team members

2) Address behavioral health need

- a) The network conducts an assessment of needed behavioral health resources to support its practices and establishes the necessary relationships to meet those needs
- b) Practices 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:
 - 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
- c) Practice 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.
- d) Primary care team members providing behavioral healthcare will have behavioral health training that covers:
 - i) Behavioral health promotion, detection, diagnosis, and referral for treatment.
- e) If 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
 - i) Guidelines on how information will be exchanged and within what timeframe
 - ii) Designating an individual to be responsible for tracking and confirming referrals
 - iii) Developing technology, if possible, to alert the primary care practice when a referral is completed
 - iv) Defining a timeframe within which a referral should be completed
 - v) Appropriate coding and billing

3) Behavioral health communication with primary care source of referral

- a) 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:
 - i) Who is responsible for updating
 - ii) Defining intervals at which assessments are made
 - iii) Adjusting treatment when not effective

ELECTIVE STANDARD 1: ORAL HEALTH INTEGRATION

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 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
 - 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 procedure of the entire oral cavity that includes:
 - 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 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
- 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

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
 - i) 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 manager, that includes:
 - i) Providing products that support oral hygiene if available (e.g., toothbrush, floss, etc.)
 - ii) Using the built in EMR tools that provide standardized education to the individual based on diagnosis
 - 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 manager
 - 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
 - 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
 - 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:
 - 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

ELECTIVE STANDARD 2: ELECTRONIC CONSULTS (E-consults)

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
 - 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.
 - 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
 - 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
 - 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**

- a) 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

- a) 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
 - 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

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;
 - b) The network develops a process for the responsible professional and/or care team to assess patient medication management needs
 - 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.
 - i) Regardless of the model, the pharmacist should have direct care experience and pharmacist credentials are reviewed
 - 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.
 - 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
 - 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, 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.
 - 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
- i) 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.
 - (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.
- b) Schedule follow-up care as needed to achieve goals of therapy.
 - i) The pharmacist and care team initiate follow-up care processes to schedule touch points with the patient and/or caregiver as outlined in the person-centered medication action plan
 - (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.

COMMUNITY HEALTH COLLABORATIVES

High-Level Shared Community Health Board Collaborative Development Process:

- 1) Transformation vendor responsibilities
- 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) Transformation vendor expectations -

- a) 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
 - 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)
 - 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 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

- 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:
 - i) Solicits input from patients and consumers to ensure the needs of the community are reflected
 - ii) Considers the capacity and capabilities of the healthcare and social service providers in the community
 - 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
 - i) 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.