PCMH+

Enhanced Care Coordination Activities Guide

State of Connecticut
Department of Social Services

Purpose

This guide will:

- Provide background about the PCMH+ Program
- Provide an overview of the required enhanced care coordination activities for all PCMH+ Participating Entities
- Provide an overview of the additional enhanced care coordination activities required of **FQHCs ONLY** *(Starting on page 15)*

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PCMH+ Background and Goals

"Person-Centered Medical Home - Plus," or PCMH+, is a new HUSKY Healthcare program launching in Connecticut (CT) in January 2017. The CT Department of Social Services (the "Department" or DSS) is contracting with providers like you, Federally Qualified Health Centers and Federally Qualified Health Center Look-Alikes (collectively, FQHCs) and Advanced Network Lead Entities (on behalf of Advanced Networks), to become PCMH+ Participating Entities. The goal of PCMH+ is to continue to enhance the quality and the care experience of Medicaid beneficiaries by building on the practice innovations you have already made in becoming CT PCMH-recognized practices.

PCMH+ is being implemented under a State Innovation Model (SIM) test grant from the Centers for Medicare and Medicaid and is built upon an Integrated Care Model (ICM) initiative. The ICM initiative has several focuses: Improving the ability of FQHCs and Advanced Networks to provide care to Medicaid beneficiaries that is integrated to provide both physical and behavioral health supports; developing the capacity of providers to identify social and resources issues; and linking members to effective community supports to support overall health and wellness for Medicaid beneficiaries. PCMH+ is guided by a number of important values:

1) Protecting the interests of Medicaid beneficiaries
2) Improving overall health and wellness for Medicaid beneficiaries
3) Creating high performance primary care practices with integrated support for both physical and behavioral health conditions
4) Building on the platform of the Department's Person-Centered Medical Home (PCMH) program, as well as the strengths and analytic capability of the Medicaid program's medical Administrative Services Organization (ASO)
5) Enhancing capacity at practices where Medicaid beneficiaries are seeking care to improve health outcomes and care experience; and
6) Encouraging the use of effective care coordination to address the social determinants of health.

Through PCMH+, participating FQHCs and Advanced Networks will provide ***Enhanced Care Coordination Activities*** to PCMH+ members. These activities expand on those you already perform as part of your PCMH recognition. ***FQHCs will also be required to provide Care Coordination Add-On Payment Activities (starting on page 15).***

This guide provides a description of these care coordination activities. All CT Medicaid beneficiaries will be eligible for assignment to PCMH+ Participating Entities, with the exception of populations who already receive extensive care coordination via other state and federal programs or who have another source of health care coverage or a limited Medicaid benefit.

Why Care Coordination?

Managing your health and navigating the health system can be confusing and challenging. Care Coordination, provided as part of a member's visit with their primary care provider, has shown tremendous promise in improving member health outcomes.

What is Care Coordination?

The Agency for Healthcare Quality and Research defines care coordination as that which "involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care. This means that the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient." On a national basis, care coordination is seen as the critical link between members, their family members and the multiple providers who provide their care.

The PCMH+ program builds on the goals of CT's existing PCMH model by incorporating new Enhanced Care Coordination Activities and Care Coordination Add-On Payment Activities in several key areas:

- Integration of primary care and behavioral health care
- Increasing provider competencies to support Medicaid beneficiaries with complex medical conditions
- Improve provider's expertise in managing members with disabilities
- Promoting linkages to community supports that can assist beneficiaries in maximizing their Medicaid benefits
- Expanding linkages and supports to include community services and natural support systems
- Promoting overall health and wellness for members

PCMH+ Participating Entity Responsibilities

As a PCMH+ Participating Entity, you will provide your HUSKY Health members with specific enhanced care coordination with the goal of improving overall quality outcomes. Combining best in class primary care with the enhanced care coordination for your members may also decrease the overall cost of care: Use of the emergency department, hospitalizations and other higher cost treatment options may be needed less frequently as you improve your member's overall health and access to needed health and community services. Participating Entities who save money for the HUSKY Health program, while demonstrating high quality care and meeting specific quality measure targets may be eligible to 'share' in the savings generated by the PCMH+ program.

Starting January 1, 2017 you will begin providing the ***Enhanced Care Coordination*** activities (and ***additional Care Coordination Activities*** if you are an **FQHC**) to your HUSKY members unless they have opted-out of the PCMH+ program.

Five Required Enhanced Care Coordination Activities

All Participating Entities

(Advanced Networks and FQHCs)

Monitoring of Enhanced Care Coordination Activities

To demonstrate compliance with the Enhanced Care Coordination requirements, Participating Entities may be asked at any time to provide supporting documentation, including relevant policies and procedures, care coordination staff qualifications, attestations, and relevant member files for review. DSS may also conduct onsite provider evaluations designed to evaluate compliance and provide technical assistance to participating providers.

Enhanced Care Coordination Activities

1. Care Coordinator Staff Requirements

Care Coordinator Staff Requirements: Availability

PCMH+ Requirement: Participating entities must select at least one of these options based on the model(s) that fit their practice:

1) Employ a full-time care coordinator dedicated solely to care coordination activities.
2) Assign care coordination activities to multiple staff within a practice.
3) Contract with an external agency to work with the practice to provide care coordination.

To meet PCMH+ model requirements, care coordinators must be located onsite. Participating entities need to demonstrate that the care coordinator's allocated time to the program will be sufficient to support members and meets the requirements of the request for proposal (RFP). You submitted the option you will be using during your RFP response. If that model needs to change during the program year, you will need to alert DSS for review of the change.

Care Coordinator Staff Requirements: Education

PCMH+ Requirement: Employ a care coordinator with behavioral health education, training, and/or experience who participates as a member of the interdisciplinary team.

PCMH+ Requirement: Define minimum care coordination education and experience requirements and determine if leveraging non-licensed staff, such as community health workers, is desired.

PCMH+ does not specify additional education requirements; however, on a national basis, staff minimums vary but generally include some of the following types of staff:

- Community Health Workers
- Registered Nurses
- Licensed or Unlicensed Social Workers
- Medical Assistants
- Unlicensed Health Coaches
- Child and Family Advocates

Enhanced Care Coordination Activities

2. Behavioral Health/ Physical Health Integration

Behavioral Health/Physical Health Screening –

PCMH+ Requirement: Use validated and standardized tools to expand behavioral health screenings beyond depression.

PCMH+ Requirement: Promote universal screening for behavioral health conditions across all populations, not just those traditionally identified as high-risk.

Use of universal screening promotes the reduction of stigma by making it a standard procedure for all patients. The use of routine screening also increases the likelihood of completion. Participating entities are encouraged to implement screening tools in both medical and behavioral health settings.

Psychiatric Advance Directives for Adults and Transition Age Youth

PCMH+ Requirement: Obtain and maintain a copy of the psychiatric advance directive in the member's file.

What is a psychiatric advance directive?
A psychiatric advance directive helps a provider to plan for the possibility that someone may lose capacity to give or withhold informed consent to treatment during acute episodes of psychiatric illness.

A psychiatric advance directive describes a person's mental health treatment preferences or names an agent to make treatment decisions for the individual, should he or she become unable to make such decisions due to psychiatric illness.

A psychiatric advance directive should be developed in collaboration with the member, family members and a behavioral health professional. Ultimately, it is the member's choice (or a family member/guardian's choice) to share their advanced directive. If a member declines to share their psychiatric advance directive, it is up to the participating entity to determine how to document and report the member's wishes.

Who are transition age youth?
Transition age youth are typically individuals between the ages of 16 and 25 years. The age range for transition age youth can vary to include children as young as 12 years. Depending on the needs of the youth they serve, participating entities may choose to expand the upper and lower age range for transition age youth.

CT Advanced Directive Resources:
http://www.ct.gov/ag/cwp/browse.asp?A=2130&BMDRN=2000&BCOB=0&C=19278

National Resource for Psychiatric Advance Directives: http://www.nrc-pad.org/

Enhanced Care Coordination Activities

2. Behavioral Health/ Physical Health Integration

Wellness Recovery Action Plan (WRAP)

PCMH+ Requirement: Obtain and maintain a copy of the WRAP or other behavioral health recovery planning tool in the member's file.

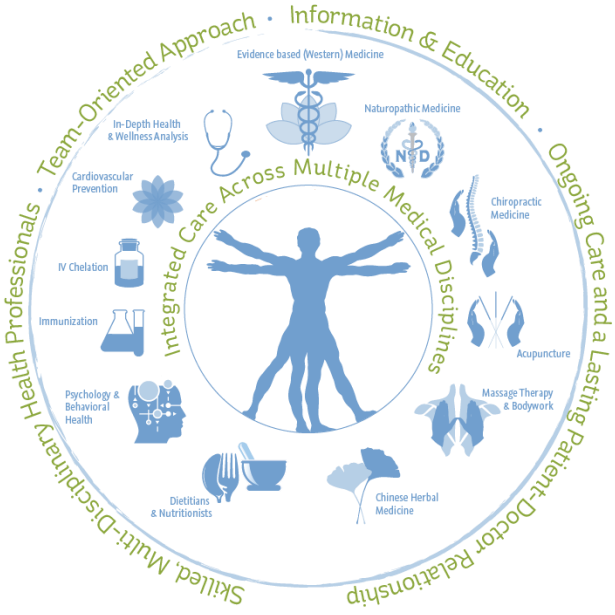
What is WRAP?
WRAP is an evidenced based practice for children and adults supported by the Substance Abuse and Mental Health Services Administration (SAMHSA). It is used both nationally and within CT's behavioral health system.

The WRAP process guides an individual through the process of identifying and understanding their personal wellness resources ("wellness tools") and then helps them develop an individualized plan to use these resources on a daily basis to manage their mental illness. The WRAP provides a tool to help a member implement the key concepts of recovery (hope, personal responsibility, education, self-advocacy, and support) in their day to day lives.

WRAPs are developed in collaboration between the individual and team members of their choosing. It can be completed on a 1:1 basis or as part of a workshop. Team members can include, but are not limited to, a behavioral health professional, family members, friends and/or peers.

Participating entities may utilize alternative behavioral health planning tools that meet similar objectives to WRAP.

National Resource for developing a WRAP:
http://store.samhsa.gov/shin/content//SMA-3720/SMA-3720.pdf



Enhanced Care Coordination Activities

3. Culturally Competent Services

Culturally Competent Services

Participating entities that practice culturally competent care recognize the impact culture has on health outcomes and implement systems and practices that respect the diverse needs of the members they serve.

Participating entities can take the first step to improve the quality of health care services given to diverse populations. By learning to be more aware of your own cultural beliefs and by being more responsive to those of your members, providers can think in ways they might not have before. This can lead to self-awareness and, over time, changed beliefs and attitudes that will translate into better health care.

National resources on cultural competence:
http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=1&lvlid=6

Culturally Competent Services – Training

PCMH+ Requirement: Annual cultural competency training for all practice staff. Cultural competency training will include the needs of individuals with disabilities.

Culturally Competent Services – Care Plan

PCMH+ Requirement: Expand any individual care plan currently in use to include an assessment of the impact culture has on health outcomes.

Culturally Competent Services – Culturally and Linguistically Appropriate Services (CLAS) Standards

PCMH+ Requirement: Compliance with CLAS standards as defined by the U.S. Department of Health and Human Services, Office of Minority Health

What are CLAS standards?
In 2000, the Office of Minority Health, under the United States Department of Health and Human Services, published the first set of national CLAS standards. The standards were expanded in 2010 and provide a framework for all health care organizations to best serve the nation's increasingly diverse communities. According to the Office of Minority Health, "CLAS standards are intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services." Implementation of CLAS standards requires change at all levels of an organization – governance, leadership and workforce. The standards also provide a framework for communication and language assistance. Last, the standards require the implementation of continuous improvement activities and accountability measures.

CLAS Standards:
https://www.thinkculturalhealth.hhs.gov/pdfs/EnhancedNationalCLASS

Enhanced Care Coordination Activities

4. Children and Youth with Special Health Care Needs

Children and Youth with Special Health Care Needs (CYSHCN)

Who are CYSHCN? The Maternal Child and Health Bureau defines CYSHCN as "those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally."

National Resources
Maternal Child and Health Bureau: http://mchb.hrsa.gov/cshcn0910/
Medical Home Data Portal for CSHCN:
http://www.childhealthdata.org/browse/medicalhome

Inclusion of Information in the Health Assessment and Health Information Record

PCMH+ Requirement: Include information from other services that CYSHCN uses in the health assessment and health information record. Such information includes:

- School information including school-based health center: The individualized education program (IEP) or 504 Plan, special accommodation, assessment of member/family need for advocacy from the provider to ensure the child's health needs are met in the school environment, how the child is doing in school and how many days have been missed due to the child's health condition and documenting the school name and primary contact
- Early intervention information: Including individualized family service plan, evaluation results and other documentation of early intervention services
- Health assessment
- Home visiting information: Including documentation of screening results, needs identified and services provided.
- Early care and education (ECE) information: Including Head Start and other early care programs, screening results, accommodations made and general coordination of care with ECE consultants
- Child welfare information: Including multidisciplinary assessments and services
- Behavioral health information including screening, evaluations and services
- Disability services information

As a participating entity, you can play a key role in the helping to identify and address health factors that can have an impact on school performance and assist the school in developing an IEP that is reflective of the member's health and other physical or behavioral conditions.

National Resource:
https://medicalhomes.aap.org/Documents/Makingthegrade.pdf

Enhanced Care Coordination Activities

4. Children and Youth with Special Health Care Needs

PCMH+ Requirement: In addition to information above, practices that serve CYSHCN will coordinate and document care using the following resources:

- The Department of Public Health (DPH) medical home initiative for CYSHCN which includes regional care coordination entities to assist medical homes in caring for and meeting the needs of CYSHCN and their families
- Training and other programs offered through the DPH regional care coordination collaboratives for CYSHCN.
- Participation in scheduled case reviews with CHN and CYSHCN program
- Family respite services offered through the CYSHCN program.
- United Way's 211 Child Development Infoline and Help Me Grow services to connect CYSHCN to parent support and other community services
- Shared Plan of Care developed under the efforts of the State Implementation Grant and other contributors, intended to promote enhanced coordinating services for CYSHCN and in collaboration with DPH, DSS and CHN

Advance Care Planning

PCMH+ Requirement: Engage in advance care planning, by way of a Shared Plan of Care, or SPoC, for discussions for CYSHCN. Advance care planning, including SPoCs, are not limited to CYSHCN with terminal diagnoses. It can occur with CYSHCN with chronic health conditions, including behavioral health conditions, that significantly impact the quality of life of the child/youth and his/her family.

PCMH+ Requirement: Develop advance directives for CYSHCN

In general, parents of CYSHCN appreciate written guidelines for their children that deal with critical life situations. Written guidelines provide a better understanding of and control over the choice of options should their child become terminal. Parents of a child with a chronic condition are typically very concerned that their wishes be implemented, even in their absence, and a written plan allows for this. As a participating entity, you may use the same advance care directive forms with your adult patients as you would for a CYSHCN.

Ultimately, it is the member's choice (or a family member/guardian's) to engage in conversations pertaining to or in the development of an advanced directive. If a member or their family/guardian declines to participate in this activity, it is up to the participating entity to determine how to document and report the member's wishes.

CT Advanced Directive Resources:
http://www.ct.gov/ag/cwp/browse.asp?A=2130&BMDRN=2000&BCOB=0&C=19278

Enhanced Care Coordination Activities

5. Competencies in Care for Individuals with Disabilities (inclusive of physical, intellectual and BH needs)

Increasing Competencies in Care for Individuals with Disabilities

PCMH+ Requirement: Expand the health assessment to include questions about:

- Durable medical equipment (DME) and DME vendor preferences.
- Home health medical supplies and home health vendor preferences.
- Home and vehicle modifications.
- Prevention of wounds for individuals at-risk for wounds.
- Special physical and communication accommodations needed during medical visits.

PCMH+ Requirement: Adjust appointment times for individuals who require additional time to address physical accommodations, communication needs, and other unique needs for individuals with disabilities. Individuals may be seen by the primary care physician and other members of the interdisciplinary team during these adjusted appointment times.

PCMH+ Requirement: Develop and require mandatory disability competency trainings to address the care of individuals with physical and intellectual disabilities. Suggested topics may include, but are not limited to: DME equipment needs for members with neuro-muscular conditions, Wheelchairs 101, Sexual Health for Individuals with Intellectual and Physical Disabilities, Supporting Individuals with Intellectual Disabilities to Become Their Own Care Coordinator and Specialized Needs of TAY.

PCMH+ Requirement: Acquire accessible equipment to address physical barriers to care (e.g., wheelchair scales, high/low exam table and/or transfer equipment, and lifts to facilitate exams for individuals with physical disabilities).

PCMH+ Requirement: Address communication barriers to care (e.g., offer important medical information and documents in Braille or large print, implement policies to ensure services animals are permitted into an appointment). Participating entities may coordinate with the Department's medical Administrative Services Organization to obtain available materials.

PCMH+ Requirement: Expand the resource list of community providers to include providers who specialize in or demonstrate competencies in the care of individuals with disabilities (e.g., mammography centers that can accommodate women who use wheelchairs, providers who will take the time to help a patient with cerebral palsy who experiences spasticity or tremors during a physical examination).

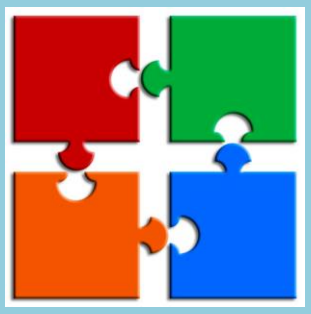
Additional PCMH+ Enhanced Care Coordination Activities

Care Coordination Add-On Payment Activities

FQHCs ONLY

Enhanced Care Coordination Activities Required of **FQHCs ONLY**

The four Additional Enhanced Care Coordination Activities for FQHCs focus on Behavioral Health/ Physical Health Integration and Transition Age Youth



• 1. Behavioral Health/Physical Health – Care Coordinator

PCMH+ FQHC Requirement: Employ a care coordinator with education, training, and/or experience who ***participates as a member of the interdisciplinary team.***

Employment of care coordinators with behavioral health expertise within primary care practices allows providers to actively identify, treat and, when necessary, refer members with behavioral health conditions. Employing a behavioral health coordinator within the practice means that behavioral health needs can often be met on the same day as a primary care visit. Ideally, the behavioral health coordinator will be responsible for tracking patients, monitoring symptoms, providing patient education, supporting treatment adherence, taking action when non-adherence occurs or symptoms worsen, delivering psychosocial interventions within their scope of practice and coordinating behavioral health services and supports that are not provided at the FQHC.

To demonstrate compliance with this requirement, FQHCs may be asked to provide supporting documentation regarding the behavioral health coordinator's qualifications, hours worked and sites supported, and evidence of participation with the interdisciplinary team.

• 2. Wellness Recovery Action Plan (WRAP)

PCMH+ Requirement: For members with co-morbid behavioral health conditions, the FQHC will develop WRAPs in collaboration with the member and family. Participating entities may choose to utilize alternative individualized behavioral health recovery planning tools that meet similar objectives to WRAP. If alternative tools are chosen, Participating entities must describe the tools they plan to use to meet this requirement and how the tools support individualized recovery planning.

To demonstrate compliance with this requirement, FQHCs may be asked to provide supporting documentation regarding wellness recovery action planning policies and procedures, copies of the recovery tools used, a listing of staff qualified to develop individualized recovery plans and a listing of the members who were provided this support during the PCMH performance year. In addition, DSS may request member files for review to evaluate compliance with this element.

Enhanced Care Coordination Activities Required of **FQHCs ONLY**

The four Additional Enhanced Care Coordination Activities for FQHCs focus on Behavioral Health/ Physical Health Integration behavioral health and Transition Age Youth

• 3. Transition-Age Youth – Care Plans

PCMH+ Requirement: Adolescents who may be aging out of child and adolescent programs frequently require support and active linkage to adult providers and services. The goal of this support is to help 'transition-age youth' avoid losing services, benefits and providers by aging out of pediatric care with no transition plan in place. FQHCs in PCMH+ are required to develop and implement a care plan for transition age youth with behavioral health challenges. The care plan should include collaborative activities to achieve success in transition and/or referrals to and coordination with programs specializing in the care of transition age youth with behavioral health challenges.

To demonstrate compliance with this requirement, FQHCs may be asked to provide supporting documentation regarding how the FQHC identifies transition age youth, policies and procedures regarding support and transition of transition age youth and transition age youth member files for evaluation.

• 4. Behavioral Health/Physical Health Integration – Use of Interdisciplinary Teams

PCMH+ FQHC Requirement: FQHCs must use an interdisciplinary team that includes behavioral health specialist(s), including the required behavioral health coordinator position described above. The interdisciplinary team is responsible for

- Driving physical and behavioral health integration
- Conducting interdisciplinary team case review meetings at least monthly
- Promoting shared appointments and developing a comprehensive care plan outlining coordination of physical and behavioral health care needs.

To demonstrate compliance with this requirement, FQHCs may be asked to provide supporting documentation regarding interdisciplinary team policies and procedures, interdisciplinary team meeting rosters and schedules and other evidence to support the behavioral health coordinator's active participation and integration within the team and practice.

Inclusion of Community and Clinical Integration Program (CCIP) Standards in PCMH+

CCIP is funded by the CT SIM or State Innovation Model. A SIM is a test grant from the Centers for Medicare and Medicaid. CCIP establishes care delivery standards and provides technical assistance in support of a) improving care for individuals with complex health needs, b) introducing new care processes to reduce health equity gaps, and c) improving access to and integration of behavioral health services.

CCIP standards have been embedded within the PCMH+ program as a method to promote the value of activities that will support the needs of Medicaid beneficiaries who are already being served by advanced networks.

All PCMH+ Participating Entities will be required to meet the following expectations throughout the period of performance:

- Participate in technical assistance and the creation and implementation of a Transformation Plan to make progress towards core standards, and any chosen elective standards.
- Identify and deploy a committed leadership team in the network that will steward the CCIP change process.
- Coordinate with the CCIP transformation vendors and participate in quality improvement activities, including regular webinars, events, office hours and others.
- Undertake the internal care delivery transformation process including engaging practices, modifying policies and procedures, modifying clinical workflows and health information systems, and providing clinical and quality improvement expertise and training to clinical staff.
- Deploy care delivery interventions across all populations, regardless of payer, while ensuring the best interests of Medicaid beneficiaries.

Detailed information about CCIP can be found in the PCMH+ RFP.