CHNCT ICM/PCMH+ Practices Care Coordination Workflow

Purpose:

To coordinate care for members with multi chronic conditions in conjunction with PCMH+ practices for enhanced care coordination. The PCMH+ practices will have oversight of care coordination for members in their practice. CHNCT's ICM program will work in collaboration with the PCMH+ practices to identify high risk members and provide educational and self-advocacy assistance to members. Both PCMH+ practices and ICM will participate in care coordination actions without duplicating resources and efforts.

Members who receive their care from PCMH+ practices are eligible for care coordination services from the care coordinator(s) located at the practice. All members assigned to a participating PCMH+ provider are eligible for PCMH+ care coordination interventions and PCMH+ providers are expected to provide outreach to all such assigned members to identify care coordination and social determinants of health needs.

Members are not eligible for PCMH+ if they are currently receiving extensive care coordination via other state or federal programs, those with another source of health care coverage or those with limited Medicaid benefit such as

- BH home participants
- Full and Partial Medicaid/Medicare dual eligible members
- Money Follows the Person waiver participants
- Members receiving Hospice Care
- Residents of facilities that are required to coordinate care for their residents (nursing homes, LTC facilities, Intermediated care facilities)
- Members in limited Medicaid benefit packages: (family planning and tuberculosis)
- Home and Community Based Services Section Waiver participants

Members who opt out of the PCMH+ care coordination service will remain eligible for services through ICM.

For those members who have an <u>active engaged</u> case with CHNCT ICM and are followed by PCMH+ practices	For those members who have a <u>pending/ active enrolled case or new referrals</u> to ICM and who are followed by PCMH+ practices	Assigned Roles and Responsibilities
The CHNCT ICM will contact the PCMH+ Care Coordinator for any Active Engaged members receiving services from ICM department ICM will share the member's plan of care with the Care Coordinator as outlined below and related to: • Members' basic needs assessment on food security, safe home and shelter • Member's access to care and participation in plan of care as prescribed by provider • Member's illness status -including co morbid and chronic conditions, medications and treatments, service utilization patterns, strengths, barriers, social and environmental support, social determinants of health, health literacy and member' self-management status and engagement in working toward achievement of self-identified goals and willingness to increase self-reliance • Any other entity (family advocates, health advocates, CMHI Care Coordinators for CYSHN etc.) that's involved in coordinating care for the member. PCMH+ will determine the care needs (if any) and proceed with Coordination of Care process unless there is an identified need that cannot be met by PCMH+. ICM will discuss transition of care with PCMH+ for existing engaged ICM members to be completed within 60 days.	The CHNCT ICM will contact the PCMH+ Care Coordinator for any non-engaged members in the ICM department. Referrals to ICM can come from our Member Engagement department, Hospital discharge reports, ADT Reports (Admission, Discharge, and Transfer Report) Inpatient Discharge Care Managers, State Agencies, and members ICM will review the reason the referral came into the department and notify the PCMH+ Care Coordinator. The Care coordinator will outreach to the member to assess for any care coordination needs and update ICM on next steps in care coordination. Update to CHNCT ICM to ensure that there is an established lead in Coordination of Care for identified members and to ensure that members are not misplaced in the coordination process.	All members attributed to a PCMH+ should be referred to the PCMH+ program for care coordination needs. In instances where the PCMH+ is unable to address the member's needs, CHNCT ICM should assist the PCMH+ if ICM can provide a higher level of clinical support. A. **Linkage with Community Partners to Address Social Determinants of Health.** All PCMH+ Participating Entities will be required to implement or demonstrate contractual relationships or informal partnerships with local community partners, including: o Community-based organizations that assist the community with housing, clothing, utility bill assistance, nutrition, food assistance, employment assistance, education, child care, transportation, language and literacy training, elder support services, etc.; o Behavioral health organizations including those providing substance use services; o Child-serving organizations; o Peer support services and networks; o Social services agencies; o Criminal justice system; o Local public health entities; o Specialists and hospitals ; o Other state and local programs, both medical and non-medical. **B. Enhanced Care Coordination Activities required by both FQHCs and Advanced Networks** 1. Behavioral Health/Physical Health Integration including the following activities: • Employ a care coordinator as a member of the interdisciplinary team (IDT); • Use standardized tools to expand behavioral health screenings beyond depression; • Promote universal screenings for behavioral health conditions across all populations,

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		• Obtain and maintain a copy of a member's psychiatric advanced directive in the member's file; • Obtain and maintain a copy of a member's Wellness Recovery Action Plan (WRAP) in the member's file. 2. Provide Culturally Competent Services including the following: • Require annual cultural competency training (including the needs of individuals with disabilities) for all practice staff; • Expand any individual care plan currently in use to include an assessment of the impact culture has on health outcomes; • Require compliance with culturally and linguistically appropriate services standards (CLAS). 3. Care Coordinator Staff Requirements – Providers must select at least one of these options based on the model(s) that fit their practice: • Employ a full time care coordinator dedicated solely to care coordination activities; • Assign care coordination activities to multiple staff within a practice; • Contract with an external agency to work with the practice to provide care coordination. 4. Provide services to Children and Youth with Special Healthcare Needs (CYSHCN) age 0-17 years: • Require advance care planning discussions for CYSHCN including but not limited to CYSHCN with terminal diagnoses, chronic health conditions, or behavioral health conditions • Develop advanced directives for CYSHCN; • Include school related information such as the

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		Individualized Education Plan or 504 plan, special accommodations, assessment of patient/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. 5. Provide competent care of individuals with disabilities (inclusive of physical, intellectual, developmental and behavioral health needs) • Expand the health assessment to include questions about durable medical equipment (DME) & DME vendor preferences, home health medical supplies, home health vendor preferences, home and vehicle modifications, prevention of wounds, and special physical and communication accommodations needed during medical visits; • Adjust appointment times for individuals who require additional time to address physical accommodations, communication needs and other unique need for individuals with disabilities; • Develop and require mandatory disability competency trainings to address the care of individuals with physical and intellectual disabilities; • Acquire accessible equipment to address physical barriers to care (such as wheelchair scales, transfer equipment, lifts, etc.); • Address communication barriers to care (for example by offering information in Braille or large print, and ensuring service animals are permitted into an appointment); • Expand the resource list of community providers to include providers who specialize in or demonstrate competencies in the care of individuals with disabilities (for example

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		mammography centers that can accommodate women who use wheelchairs, or providers who will take the time to help members with cerebral palsy who experiences spasticity or tremors during a physical examinations). 6. Evaluate and utilize the results of provider profile reports, if available, on a quarterly basis to improve quality of care. C. **The following Care Coordination Add-On Payment Activities will only be required of FQHC participating entities** : 1. Behavioral health/ Physical health Integration • Employee a care coordinator with behavioral health experience who serves as a member of the IDT and has the responsibility for tracking patients, reporting adverse symptoms to the team, providing patient education, supporting treatment adherence (participation in treatment plan), taking action when non-adherence (non-participation in treatment plan) occurs or symptoms worsen, delivering psychosocial interventions and making referrals to behavioral health services outside of the FQHC as needed; • Develop WRAPS in collaboration with the patient and family. 2. Transition-Age Youth (TAY) • Expand the development and implementation of the care plan for TAY with behavioral health challenges (for example collaborative activities to achieve success in transition and/or referrals to and coordination with programs specializing in the care of TAY with behavioral health challenges). 3. Require the use of an IDT that includes a behavioral health specialist(s), including the required behavioral health coordinator position. • Demonstrate that the IDT has the responsibility for driving

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		physical and behavioral health integration, conducting IDT case review meetings at least monthly, promoting shared appointments and developing a comprehensive care plan outlining coordination of physical and behavioral health care needs. **CHNCT ICM** will support PCMH+ coordination of care activities as needed from the following multidisciplinary team members if needed: • **Care Managers** may assist on specific diagnosed conditions (asthma, diabetes, COPD, sickle cell disease, heart failure, coronary artery disease, etc.); coordination for organ transplant services; assist in the process for members with gender dysphoria; and assist temporarily when a higher level of clinical support is needed than what the care coordinator at the PCMH+ practice can provide. • **Registered Dietician** -If the PCMH+ employs dieticians and/or Certified Diabetic Educators , nutrition counseling is expected to be provided o If PCMH+ does not employ Registered Dieticians; CHNCT ICM Registered Dietitian may provide nutritional counseling to members for whom it is indicated.