# PCMH+ — ENHANCED CARE COORDINATION ACTIVITIES

Updated November 10, 2016 and effective for dates of service on and after January 1, 2017

The following grid presents the finalized set of enhanced care coordination activities required under the Connecticut Person-Centered Medical Home – *Plus* (PCMH+) program.

PCMH+ Participating Entities will provide Enhanced Care Coordination Activities to PCMH+ Members. The Enhanced Care Coordination Activities leverage national best practices in care coordination and exceed the FQHC, HRSA, and Patient-Centered Medical Home recognition requirements as defined by NCQA or ambulatory care entities with a Primary Care Medical Home certification from The Joint Commission.

- All PCMH+ Participating Entities must perform the required Enhanced Care Coordination Activities.

- PCMH+ Participating Entities that are FQHCs will provide both the Enhanced Care Coordination Activities and Care Coordination Add-On Payment Activities, which will be reimbursed through the Care Coordination Add-On Payment.

| Enhanced Care Coordination Category | Enhanced Care Coordination Activities Required for Both FQHCs and Advanced Networks |
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| **Behavioral Health/ Physical Health Integration** | **Care Coordinator:**<br>1. Employ a care coordinator with behavioral health education, training and/or experience who participates as a member of the interdisciplinary team. |
| | **Screening for Behavioral Health Conditions:**<br>2. Use standardized tools to expand behavioral health screenings beyond depression.<br>3. Promote universal screening for behavioral health conditions across all populations, not just those traditionally identified as high-risk. Providers are encouraged to implemented screening tools in both medical and behavioral health settings. |
| | **Psychiatric Advance Directives for Adults and Transition Age Youth:**<br>4. Obtain and maintain a copy of the psychiatric advance directive in the member's file. |
| | **Wellness Recovery Action Plan (WRAP) or Other Behavioral Health Recovery Planning Tool:**<br>5. Obtain and maintain a copy of the WRAP or other behavioral health recovery planning tool in the member's file. |
| **Culturally Competent Services** | **Training:**<br>6. Require annual cultural competency training for all practice staff. Cultural competency training will include the needs of individuals with disabilities. |
| | **Care Plan:**<br>7. Expand the individual care plan currently in use to include an assessment of the impact culture has on health outcomes. |

| Enhanced Care Coordination Category | Enhanced Care Coordination Activities Required for Both FQHCs and Advanced Networks |
|---|---|
| | **Cultural and Linguistically Appropriate Services (CLAS) Standards:**<br>8. Require compliance with CLAS standards as defined by the Department of Health and Human Services, Office of Minority Health. |
| **Care Coordinator Staff Requirements:** ***Availability*** | **Care Coordination Availability:** ***Providers must select at least one of these options based on the model(s) that fit their practice:***<br>9. Employ a full time care coordinator dedicated solely to care coordination activities.<br>10. Assign care coordination activities to multiple staff within a practice.<br>11. Contract with an external agency to work with the practice to provide care coordination. |
| **Care Coordinator Staff Requirements:** ***Education*** | **Care Coordinator Education:**<br>12. Define minimum care coordinator education and experience and determine if leveraging non-licensed staff such as community health workers is desired.<br><br>Staff minimums can vary nationally but generally include some of the following types of staff:<br>*Clinical and Non-Clinical Staff:*<br>• Registered Nurse.<br>• Medical Assistant.<br>• Un/Licensed Social Worker.<br>• Un/Licensed Community Health Worker.<br>• Unlicensed Health Coach.<br>• Child and Family Advocate. |
| **CYSHCN:**<br>**Age 0–17 years** | **Advance Care Planning:**<br>13. Require 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, which significantly impact the quality of life of the child/youth and his/her family.<br>14. Develop advance directives for CYSHCN. |

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| | **Health Assessment:**<br>15. Include information from other services that CYSHCN uses in the health assessment and health information record. Such information includes:<br>A. School information including school-based health center: The individualized education program 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.<br>B. Early intervention information: Including individualized family service plan, evaluation results and other documentation of early intervention services.<br>C. Home visiting information: Including documentation of screening results, needs identified and services provided.<br>D. 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.<br>E. Child welfare information; including multidisciplinary assessments and services.<br>F. Behavioral health information including screening, evaluations and services.<br>G. Disability services information |
| | 16. **In addition to information above, practices that serve CYSHCN will coordinate and document care using the following resources:**<br>A. 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.<br>B. Training and other programs offered through the DPH regional care coordination collaboratives for CYSHCN.<br>C. Participation in scheduled case reviews with CHN and CYSHCN program.<br>D. Family respite services offered through the CYSHCN program.<br>E. United Way's 211 Child Development Infoline and Help Me Grow services to connect CYSHCN to parent support and other community services.<br>F. Shared Plan of Care developed under the efforts of the State Implementation Grant intended to promote enhanced coordinating services for CYSHCN and in collaboration with DPH, DSS, and CHN. |
| **Competencies in Care for Individuals with Disabilities**<br><br>**(Inclusive of physical, intellectual, developmental and behavioral health needs)** | **Health Assessment:**<br>17. Expand the health assessment to include questions about:<br>A. Durable Medical Equipment (DME) and DME vendor preferences.<br>B. Home health medical supplies (e.g. ventilator and tracheostomy supplies) and home health vendor preferences.<br>C. Home and vehicle modifications.<br>D. Prevention of wounds for individuals at risk for wounds.<br>E. Special physical and communication accommodations needed during medical visits. |

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| | **Appointment Times:**<br>18. 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. |
| | **Training:**<br>19. Develop and require mandatory disability competency trainings to address the care of individuals with physical and intellectual disabilities. |
| | **Accessibility of Office Environment:**<br>20. Acquire accessible equipment to address physical barriers to care (e.g. wheelchair scales, a high/low exam table and/or transfer equipment and lifts to facilitate exams for individuals with physical disabilities).<br>21. Address communication barriers to care (e.g. offer important medical information and documents in Braille or large print, implement policies to ensure service animals are permitted into an appointment). Providers may coordinate with the Department's medical Administrative Services Organization to obtain available materials. |
| | **Resource List:**<br>22. Expand the provider 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 member with cerebral palsy that experiences spasticity or tremors during a physical examination). |
| **Provider Profile Reports** | **Provider Profile Report Utilization:**<br>23. Evaluate and utilize results of the provider profile reports, to the extent available, on at least an annual basis to improve quality of care.<br><br>Provider profile reports will analyze measures of health care and clinical quality measure results for PCMH+'s providers. The report will provide quantitative provider feedback at the statewide practice setting and individual provider/practice level that can be used to direct resources and inform policy. |

| Enhanced Care Coordination Category | Care Coordination Add-On Payment Activities - FQHCs ONLY |
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| **Behavioral Health/Physical Health Integration – FQHCs ONLY** | **Care Coordinator**<br>1. Employ a care coordinator with behavioral health experience and assign them responsibility for tracking members, monitoring symptoms, providing member education, supporting treatment adherence, taking action when non-adherence occurs or symptoms worsen and delivers psychosocial interventions. |
| | **WRAP or Other Behavioral Health Recovery Planning Tool**<br>2. Develop WRAPs or other behavioral health recovery planning tools in collaboration with the member and family. |
| | **Transition Age Youth:**<br>3. Expand the development and implementation of the care plan for transition age youth (TAY) with behavioral health challenges (e.g. 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). |
| | **Interdisciplinary Teams:**<br>4. Require the use of an interdisciplinary team that includes behavioral health specialist(s), including the required behavioral health coordinator position.<br>A. Demonstrate that the interdisciplinary team has the responsibility 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 and physical and behavioral health care needs. |