Care Coordination
PCMH+ Collaborative Meeting

April 12, 2017

Connecticut Department of Social Services

Making a Difference

What we will cover today

DSS Coordination Activities, including PCMH+ Enhanced Care Coordination

ICM Care Management

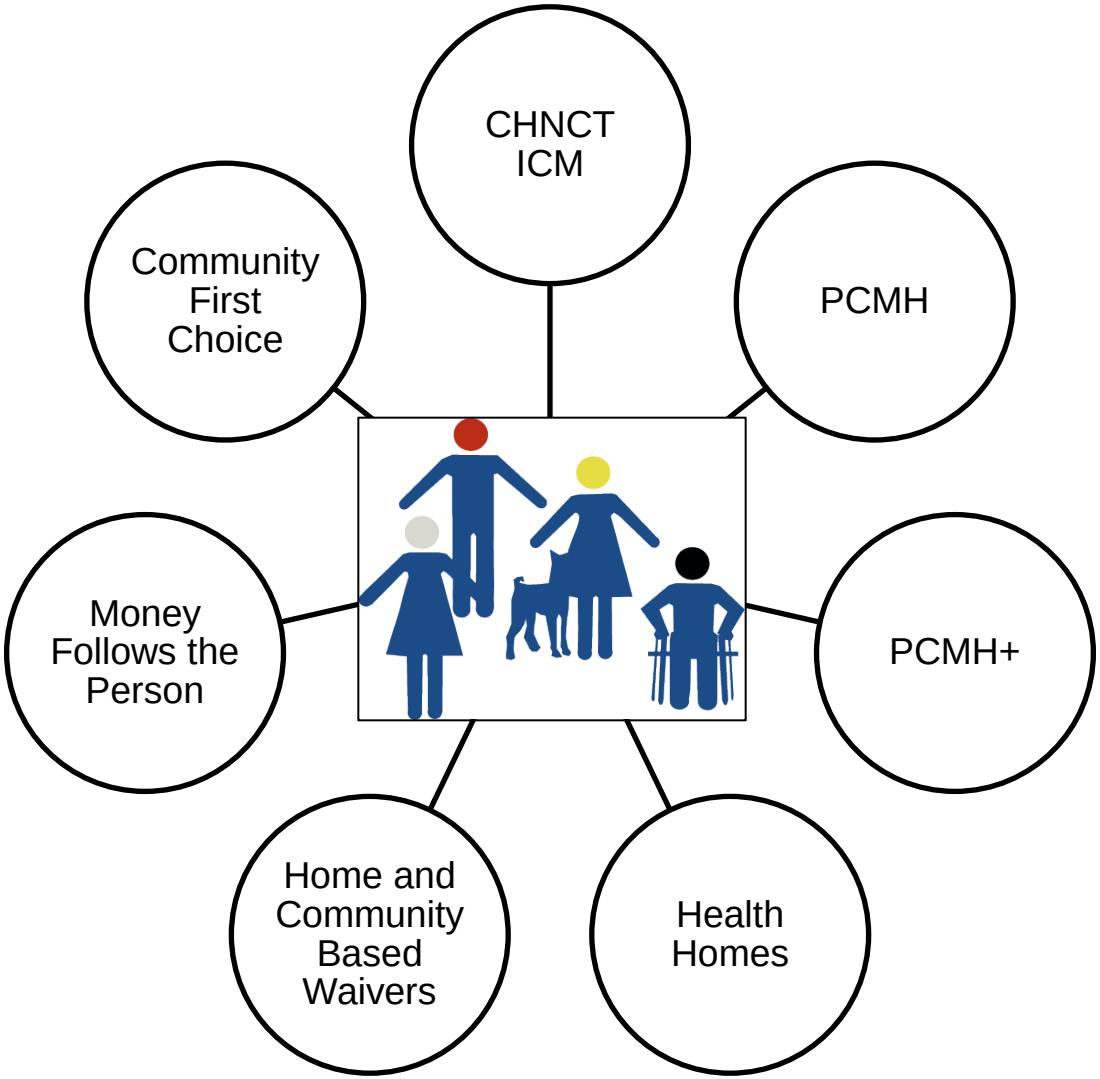
Questions

DSS CARE COORDINATION

DSS Care Coordination Population Targets

- Members served by Medicaid who need community-based Long-Term Services and Supports (LTSS)
- Members with need for support in accessing and coordinating their services
- Members with behavioral health conditions health conditions who receive services from Local Mental Health Authorities (LMHA)
- Members served by Medicaid who receive their care at Federally Qualified Health Centers and “advanced networks”

DSS Care Coordination Initiatives



PCMH+ ENHANCED CARE COORDINATION

Building on Connecticut's PCMH Model

PCMH+ Key Areas					
Integration of primary care and behavioral health care.	Expanding linkages and supports to include community services and natural support systems.	Promoting linkages to community supports that can assist members in maximizing their Medicaid benefits.	Improve provider's expertise in managing members who have disabilities.	Promoting overall health and wellness for members.	Increasing provider competencies to support members who have disabilities and special healthcare needs.

Five Required Enhanced Care Coordination Activities for **ALL** PCMH+ Participating Entities

1. Care Coordinator:
- **Availability**
- **Education**

2. Behavioral Health/Physical Health (BH/PH) Integration:
- **Screening**
- **Psychiatric Advance Directives for Adults and Transition Age Youth**
- **Wellness Recovery Action Plan (WRAP)**

3. Culturally Competent Services Requirements:
- **Annual cultural competency training**
- **Expanding care plan**
- **CLAS Standards**

4. Children and Youth with Special Health Care Needs:
- **Inclusion of information in the health assessment and health information record**
- **Advance care planning**

5. Competencies in Care for Individuals who have Disabilities:
- **Increasing Competencies in care: Health assessment, appointment times, training, equipment, communication aids and resource list**

Four Additional Enhanced Care Coordination Activities for **FQHCs only**

Care Coordination Add-on Activities

Behavioral Health / Physical Health

1. Care Coordinator with behavioral health education, training and/or experience
2. Wellness Recovery Action Plan (WRAP)
3. Transition Age Youth (TAY) Care Plans
4. Use of Interdisciplinary Teams

Care Coordination Example 1

Alex is an 8 year old boy who has been having vision problems at school. He has no other health concerns.

How the Care Coordinator can help

- Referral to a pediatric eye doctor
- Help obtaining glasses if prescribed for Alex

Care Coordination Example 2

Jane is a 38 year old who has recently found out she has high blood pressure. Jane doesn't understand high blood pressure and is worried about getting her medications because she does not have a car.

How the Care Coordinator can help

- Education on managing high blood pressure
- Education on taking medications correctly
- Help finding healthy food in her neighborhood
- Help finding a pharmacy that can deliver medications

Care Coordination Example 3

Mary is a 45 year old who has diabetes and is also homeless and living in a shelter. Mary does not understand diabetes or what she should be eating. She does not check her blood sugar levels because she doesn't have a glucometer. She wants a safe place to live.

- Educating about diabetes and healthy blood sugar levels
- Educating about healthier food options at the shelter
- Obtaining a blood sugar testing kit and teaching Mary how to use it
- Talking to the local housing agency(s) to identify housing options and eligibility standards
- Scheduling follow up appointments and arranging transportation
- Frequent call checks between physician appointments
- Finding a pharmacy to deliver medications to the shelter
- Teaching Mary what to do if her blood sugar is low or high

CHNCT’S INTENSIVE CARE MANAGEMENT PROGRAM

ICM/PCMH+ Collaboration

- Coordinate care for PCMH+ members.
- All PCMH+ members should be referred to their PCMH+ practice for care coordination.
- CHNCT ICM assists the PCMH+ practice if ICM can provide a higher level of clinical support.
- PCMH+ and ICM will make every effort not to duplicate resources and efforts.

CT Medicaid's ASO, CHNCT, provides
Intensive Care Management
to eligible HUSKY members

For members already in ICM…

- CHNCT ICM will contact the PCMH+ Care Coordinator and share the member's plan of care.
- PCMH+ will determine care needs and proceed to coordinate care, unless there is an identified need that PCMH+ cannot meet.
- ICM will discuss transition of care with PCMH+ to be completed within 60 days.

For members identified as potentially eligible for ICM…

- CHNCT ICM will contact the PCMH+ Care Coordinator for any members potentially eligible for ICM.
- The PCMH+ Care Coordinator will outreach to the member to assess for any care coordination needs.
- The PCMH+ Care Coordinator will update ICM on next steps in care coordination.
- If member is enrolled in ICM, ICM and PCMH+ Care Coordinator will establish a care coordination lead.

CHNCT ICM Services

- **Care Managers**
  - Assist on specific diagnosed conditions (asthma, diabetes, COPD, sickle cell disease, heart failure, coronary artery disease, etc.).
  - Coordinate organ transplant services.
  - Assist members with gender dysphoria.
  - Assist temporarily when a higher level of clinical support is needed.
- **Registered Dietician**
  - If PCMH+ does not employ Registered Dieticians, CHNCT ICM Registered Dietitian may provide nutritional counseling to members for whom it is indicated.

QUESTIONS & ANSWERS