Connecticut HUSKY Health:

Person-Centered Medical Home +

(PCMH+)

Update

Southwest Community Health Center

July 14, 2017

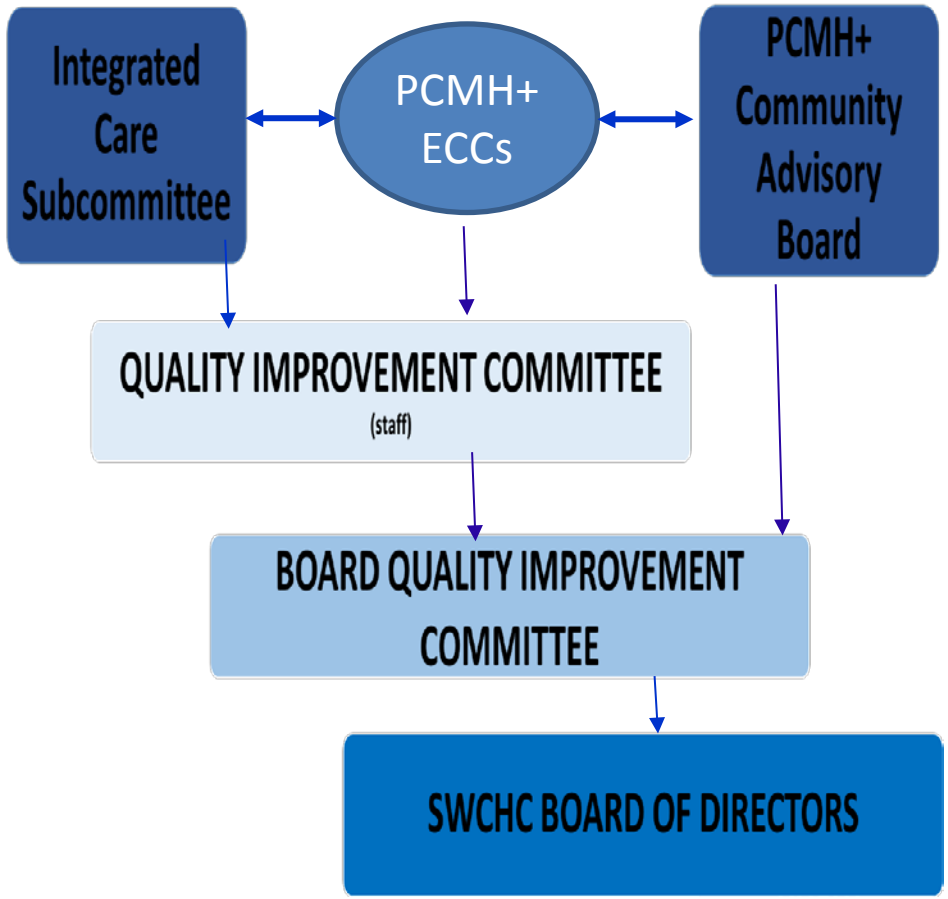
- **Hiring:**

4 Enhanced Care Coordinators (ECCs) All cross trained

- 2 Medical, 2 Behavioral Health (2 are bilingual)
- All with Bachelors Degrees, one with Masters
- All with varied experience working with clients with disabilities, mental health challenges, age related deficits, and housing needs.

Program Reporting Structure:

- There is one Lead ECC
- The Medical ECCs report directly to the Chief Medical Officer (CMO) and the Behavioral Health (BH) ECCs report directly to the Chief BH Officer
- The CMO & the Director of QA/QI report all PCMH+ activities internally and to the Board Quality Improvement Committee (BQIC).
- The Chair of the Community Advisory Board will report to the BQIC.
- The Chair of the BQIC will the report the information to the full Board.



Southwest Community Health Center

Care Management/Navigation Approach

Our Premise:

- Outreach/referral
- Behavioral Health/Medical Integrated Care Model
- Individualized care management

Our Process:

- Reports and referrals are used to identify and to assess health risks/gaps in care for attributed members
- Individualized care plan is developed for each member
- Documentation in EHR Care Management Template

Tools used:

- Husky Provider Profile reports
- DST Care Analyzer Reports
- NextGen EHR reports to identify TAY, CYSHCN, BH/medical members
- ICM referrals
- Department referrals

Strategies for Engagement of Medicaid Members

- ECCs phone members, provide dedicated contact information, and educate the member as to the importance of follow-up.
- "Warm hand-offs" to/from other departments – builds trust, eliminates stigma/barriers
- Scheduled and walk-in appointments with members
- Internal referrals to ECCs at request of member's provider – asked what we can do to further assist
- Coordination with inter-program referrals for Ryan White - HIV/McKinney Homeless/WIC
- Modifications to case management template in EHR for documentation, reporting, and tracking

- Vignettes:
  - OB member
  - BH member
  - HIV member
- Outcomes:
  - Holistic care
  - Improved processes for:
    - Documentation
    - Treatment planning
    - Staff communication
    - Use Integrated Care Meetings to identify opportunities for more effective care delivery
    - Improved member & provider satisfaction
- Challenges:
  - No access to BH data
  - Need improved hospital discharge information
  - members contact information frequently changes, hindering outreach

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Yale New Haven Health – Northeast Medical Group

July 14, 2017

PCMH+ update:

- NEMG Advanced Network at a Glance
  - Patients attributed to 88 providers across 39 practices, across Fairfield, New Haven, and New London counties
  - 7509 patients attributed at program start
  - 5872 patients attributed as of July, 2017
  - Approximately 34% of attribution is pediatrics patients

Patient Engagement – Emmi Outreach

Pediatrics

- 914 patients outreached
- 464 patients contacted
- 133 calls routed for real-time scheduling
- Information about exams due and scheduling provided to all

Adult Primary Care

- 1,372 patients outreached
- 608 patients contacted
- 151 calls routed for real-time scheduling
- Information about exams due and scheduling provided to all

Care Management & Navigation – Health Leads

- Community Advocates program is modeled after Health Leads, linking patients with community resources.
- Patients screened for social determinants of health
  - Food
  - Housing
  - Transportation
  - Access to health care services & prescriptions
- Patients enrolled have screened positive for one or more social determinants and have agreed to navigation.
- Patients are paired with a patient navigator and a student advocate.
- Patient concurrently navigated to health services to close gaps in care.

Care Management & Navigation – Health Leads

Patient Story

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Fair Haven Community Health Center

July 14, 2017

PCMH+ update: Support of Meaningful Transformation

- Hiring of additional enabling and engagement staff
  - Improved patient engagement
  - Additional patient focus groups
- Operationalized screening, follow-up: SDoH
- Focus on wellness: screening, adolescents
- Starting to use risk profiles for increased care
- Significantly improved hospitalization follow-up

PCMH+ update: Making Connections

- Care management/navigation approach
  - Team-based
  - Triage system
  - Family-focused
  - Connections to community resources
- Strategies for engagement of Medicaid members
  - Patient story

Connecticut HUSKY Health:

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Update

Cornell Scott Hill Health Center

July 14, 2017

PCMH+ update: Hiring

PCMH (June 2013 to present)

Core PCMH team

- 2 providers
- 1 nurse
- 2 medical assistants

Auxiliary Members

- Behaviorist embed
- Pharmacist – Medication Therapy Mgt
- Continuous screening for Dental need

Care Coordination

- **One Americorp volunteer for the entire agency**

PCMH+ (January 2017 to present)

Enhanced Care Coordination

- 1 Director of Care Coordination
  - Former Nurse Manager of our largest Primary Care Site
  - Former nurse from our Inpt Detox facility
  - Also supervises our 7 person referral team
- 1 Assistant Mgt – Complex Care Coordination
- 1 Behavioral Health Complex Care Manager
- 5 Care Coordinators
  - Includes coverage for specialties

7 FTE's on direct service

- 2 Americorp volunteers (planning to add in the fall)

PCMH+ update: Care management/navigation approach

PCMH (June 2013 to present)

i2i Tracks (Population Health software)

- Our population health tool supported search for at risk populations.
- Engagement of that populations was a pod level responsibility.

Medication Therapy Mgt

- Onsite capacity to engage patients in medication review/reconciliation

Referral Tracking

- Our referral coordinators communicate via eHR status of care.

PCMH+ (January 2017 to present)

Director of Care Coordination

- Combined oversight of Care Coordination & Referral teams .

Leverage PTN to improve data

- New eHR based electronic referral tracking module.
- New eHR clinical quality measure dashboards
- Building new risk stratification tools

Complex Care Management

- PCMH+ flags to engage pts across org
- Risk stratification drives proactive outreach to higher risk patients
- New Wellness Recovery Action Plan assessment forms

PCMH+ update: Strategies for engagement of Medicaid members

PCMH (June 2013 to present)

- Outreach based on condition
- Consumer board member feedback on QA/QI reports in board meeting
- Continuous monthly polling for patient satisfaction (PRC as vendor)

PCMH+ (January 2017 to present)

- Improved outreach based on risk.
- All members engaged upon accessing any services (e.g. med, BH, SA, dental)
- High risk members outreach by phone and face to face appointments by provider recommendation
- Home visits as needed
- Med/Peds WRAP drives additional engagement & community linkage
- WRAP leads to Self Management Goal setting and treatment planning
- PCMH+ members added to our QA/QI team

Success Story - Katherine

Received a physician referral for small child to Birth to Three, followed by a request for 2nd child in same household. Mother was initially resistant to additional support for her 2 children (1 with developmental delay, 1 with failure to thrive). Mother accepted, then later cancelled appointments, until such time that Katherine was able to do a home visit. That visit led to revelation that mother was not clear on how to prepare formula for one child…so she was taught at that visit. Katherine also coordinated with and for the mother to receive assistance from our Diaper bank, Husky, and Birth to Three.

Success Story - Natasha

Natasha approached a member who arrived for a primary care visit. At first, the patient appeared agitated, stood up and relayed that he was not interested in talking to Natasha, but the longer they conversed, the more details he shared. He conveyed that he was in pain and had not slept in weeks. Natasha reviewed his plan of care with him and realized his frustration stemmed from a missed attempt connecting him with the proper party to ensure a pain relieving procedure could take place. Natasha navigated him through the system to ultimate destination. Patient received care and showed significant improvement. Natasha later worked with staff on how to better coordinate this type of care in the future.

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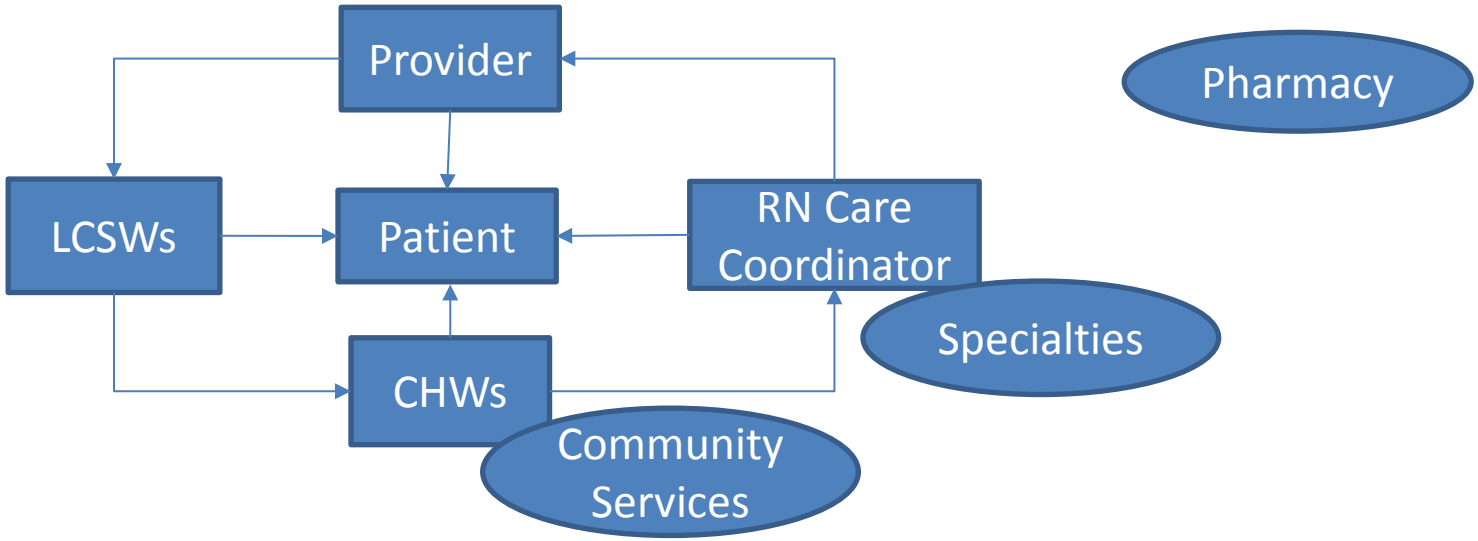
Optimus Health Care

July 14, 2017

- **PCMH+ update:** OHC has engaged just over 200 PCMH+ members since Jan 1st.
  - 257 ongoing and successful care coordination activities recorded (activities involving other resources within and outside of Optimus)
  - 159 successful community resources & clinical referrals
  - 104 completed person centered care plans
- **Hiring:** 6 CHWs, 1 RN Care Coordinators
  - Senior Leader, Senior Clinical Leader, Behavioral Health Team Lead, LCSWs.

- **Care management/navigation approach:**



Patient Centered Approach:

- Needs identified by care team,
- Patient may be engaged by the provider, RN CC or CHW
- Assessment/Screenings
- Warm hand off to RN or CHW care coordinator
- Needs of the Whole Person Addressed

- **Strategies for engagement of Medicaid members:**
  - Orient all OHC patients to PCMH practice
  - Care Team approach – "What matters to the patient"?
  - Sensitive to services only accessible to Medicaid members
- **Opportunities:** Address the social determinants of health. Need referral specialists. EMR Interoperability.
- **Barriers:** Availability of space, Provider time, Potential Sustainability.