12 Patient Centered Initiatives

Revision Dates: August 15, 2014, September 1, 2016

Effective Date: January 1, 2014

Broad Standards:

The Managed Care Organization (MCO) shall establish ~~a~~ patient centered initiatives based on the National Committee for Quality (NCQA), Joint Commission on Accreditation of Healthcare Organizations (JHACO) or Accreditation Association for Ambulatory Health Care (AAAHC) Patient-Centered Medical Home (PCMH) recognition program.

The MCO shall develop ~~a~~ patient-centered, "whole person" models of care that emphasize~~s~~ primary medical care that is comprehensive, team-based, coordinated, accessible and focused on quality and safety.

~~**Eligible Providers:**~~**Patient-Centered Medical Homes**

The MCO shall develop PCMH initiatives with Primary Care physicians (DO or MD), Nurse Practitioners or Physician Assistants as defined by MAD regulation.

Guiding principles of a Patient Centered Medical Home (PCMH):

~~PCMH Principles~~

- Every Member has a Primary Care Provider (PCP)
- Care is provided by a physician-directed team that collectively cares for the Member; and
- Care is coordinated and/or integrated across all aspects of health.

~~PCMH Model~~

The MCO shall develop PCMH models that:

- Provide patient-centered care;
- Practice evidence-based medicine;
- Participate in continuous quality improvement;
- Engage patients to actively participate in decision-making and provide feedback related to their care;

- Use Health Information Technology (HIT) and promote data exchange through a Health Information Exchange (HIE) to support care delivery; and
- Provide enhanced access to care including but not limited to extended office hours outside of 8:00 AM to 5:00 PM (Mountain Time), open scheduling, and alternative modes of communication including web-based or telephonic options.

PCMH Standards:

- Access to care (i.e. same day appointments, extended hours, group and e-visits, and patient portals). Appointments based on condition and the provider can accommodate same day scheduling as needed.
- In-person access
- After-hours access
- Telephone and electronic access
- Accountability
- Performance and clinical quality improvement
- Comprehensive whole person care
- Preventive services
- Medical services
- Mental health, substance abuse, and developmental services
- Comprehensive health assessment and intervention scope of Services
- Continuity
- Personal clinician assigned
- Personal clinician continuity
- Organization of clinical information
- Clinical information exchange
- Specialized care setting
- Coordination and Integration
- Population data management
- Electronic health record
- Care coordination

- Test & result tracking
- Referral & specialty care coordination
- Comprehensive care planning
- End of life planning
- Person and family centered care
- Language / cultural interpretation
- Education & self ~~?~~management support
- Experience of care

PCMH Participation Requirements:

In order to participate, practitioners must:

- Meet the six PCMH standards outlined above;
- Adopt and implement evidence-based diagnosis and treatment guidelines;
- Fully implement an electronic medical record system and participate in the NM Health Information Exchange (HIE);
- Identify and partner with the MCO to manage high need patients; implement a system for care coordination;
- Measure and report PCMH quality measures as defined by the HSD/MAD which may include HEDIS or patient satisfaction data; and
- Have a continuous quality improvement plan that references medical home standards.

School Based Health Center Medical Homes:

The MCO shall develop a medical home model of care for School Based Health Centers (SBHC) that emphasizes primary medical care that is continuous, comprehensive, coordinated, accessible, compassionate and culturally appropriate for youth. The SBHC medical home model core elements ~~include:~~should include:

~~Enhance access and continuity that includes:~~

- Access during office hours~~;~~, ~~includes~~ including same day scheduling and telephone access;
- After-hours access~~; --~~ after hours clinical advice via phone/electronic access to providers;

- Continuity/Coordination~~; --~~ each student is assigned a personal physician and the practice is responsible for coordinating care;
- Students receive information about the role of the medical home~~; , coordinating~~ coordination of care, how to ~~getting~~ obain advice after hours, the responsibility to share information about care received in other places and ~~self management~~self-management; and
- Meet cultural, linguistic and health needs of the population served.

~~Identify and manag~~ Management of the SBHC PCMH~~e~~ patient population ~~that~~ must include~~s~~:

- Collection ~~and use~~ of data for population management~~; --~~ identify students in need of preventive or chronic care services, those whom have not recently been seen by a practitioner or those ~~with~~ taking specific medications;
- Patient ~~Information~~ information and clinical data collected and entered into an Electronic Health Record (EHR~~);)--~~ demographics, health insurance, and vital stats (height, weight, BMI, plotted on a growth chart); and
- Comprehensive health assessment completed for each student~~; --~~ immunization assessment, family/social/cultural issues, depression screening, tobacco use, behaviors affecting health and medical history.

Care coordination and care ~~Plan~~ plans ~~and manage care that~~ must include~~s~~:

- ~~Care management; providing a~~ A written plan of care ~~to~~ for student/family that includes a self-management plan when appropriate;
- ~~Identify~~ Identification of high risk students;
- Implementation of evidence based guidelines;
- Medication management and ability to conduct E-prescribing;
- Referrals to community resources as needed;
- Referral tracking and documentation of follow up;
- Tracking of tests and follow up with flagging of abnormal tests;
- Transition management, including to adult healthcare options.

~~Provide self-care support and community resources that includes:~~

~~Support self-care process; develop self managementself-management plan and provide educational resources~~

~~Provide referrals to community resources; maintain a list of key community resources~~

~~Track and coordinate care that includes:~~

~~Referral tracking and follow-up~~

~~Test tracking and follow up; flag abnormal tests~~

~~Manage transitions; including to adult care~~

SBHCS PCMS should ~~Measure~~ measure and improve care ~~that includes~~ with the following objectives:

- Measure performance to improve clinical quality; for at least three (3) preventive or chronic conditions;
- Measure student experience at the SBHC; and
- Implement Continuous Quality Improvement

PCMH Monitoring:

The MCO shall use a standardized set of measurements including: utilization, cost and quality measures to monitor:

- Preventive care;
- Chronic disease management;
- Acute care;
- Over utilization; and
- Safety

The MCO shall measure patient satisfaction using surveys and other predefined sources of information annually.

PCMH Payment Methodology

An enhanced payment methodology for PCMHs ~~must be standardized between all contracted MCOs~~may include:

~~Methodology may include:~~

- Ongoing fee-for-service payments;
- Tiered per member per month (PMPM) payment based on PCMH recognition level including a base level if practice is not NCQA, JHACO, or AAAHC recognized.
- Enhanced payment to practices that meet quality targets (pay for performance); and
- Shared savings model.

Health Homes

The MCO shall comply with Section 2703 of the Patient Protection and Affordable Care Act (PPACA) and in accordance with the Medicaid State Plan Amendment to provide a comprehensive system of care coordination for individuals with chronic conditions.

The MCO shall ensure that the Health Homes provide the delegated care coordination functions for Members enrolled with the Health Home. Delegated Health Home Care Coordination responsibilities include the following:

- Perform a Comprehensive Needs Assessment (CNA) for Health Home Members who meet the criteria. For members of the Health Home using the Treat First Model, an in-home visit will be required within 6 months;
- Assign Care Coordination levels for each Health Home Member;
- Adhere to Care Coordination activities for level 2 or level 3 as set forth in the HSD Policy Manual;
- Develop and implement Comprehensive Care Plans (CCP) for Members in Care Coordination levels 2 and 3 to monitor, on an ongoing basis, the effectiveness of the care coordination process;
- Develop and implement policies and procedures for ongoing identification of Members who may be eligible for a higher level of care coordination;
- Develop and implement policies and procedures for ongoing care coordination to ensure that Members receive all necessary and appropriate care;
- Monitor and evaluate a Member's emergency room and behavioral health crisis services utilization;
- Participate in the institutional setting's care planning process and discharge planning processes;

- Maintain individual case files for each Member;
- Ensure adequate care coordination staffing requirements, including training required to perform the care coordination activities;
- Ensure that Members transition to another MCO in accordance with HSD's protocols.

The MCO will provide available Member documentation to the Health Home, including but not limited to:

- History & Physical
- Individualized Service Plan
- HRA
- CNA
- Functional Assessment
- CCP
- Emergency & Back-up Plan
- Behavioral Health Co-Management summary notes
- Advance Directive

The MCO will provide training to the Health home Agencies regarding the criteria indicating a Health Home Member may be eligible for a Nursing Facility Level of Care (NF LOC). The Health Home Care Coordinator and the MCO Care Coordinator will conduct the NF LOC assessment together for Members who meet the criteria. The MCO will complete the Allocation Tool and developing the Community Benefit section of the Member's CCP. The Health Home Care Coordinator will coordinate and monitor the utilization of the Community Benefit Services. The MCO will retain the budget for Members who utilize Self-Directed Community Benefits (SDCB). The Health Home Care Coordinator will conduct the Care Coordination and Care Management for the Health Home Member.

Health home providers must integrate and coordinate all primary, acute, behavioral health and long-term care services that support and treat the whole-person across the lifespan.

Health Home Core Services:

A. Comprehensive Care Management~~;~~ must include:

- Assessment of preliminary risk conditions and health needs;
- Care Management Plan development, which will include client goals, preferences and optimal clinical outcome and identify specific additional health screenings required based on the individual's risk assessment;
- Assignment of health team roles and responsibilities;
- Development of treatment guidelines for health teams to follow across risk levels or health conditions;
- Oversight of the implementation of the Care Management Plan which bridges treatment and wellness support across behavioral health and primary care;
- Through claims-based data sets and patient registries, monitoring of individual and population health status and service use to determine adherence to or variance from treatment guidelines; and
- Development and dissemination of reports that indicate progress toward meeting outcomes for client satisfaction, health status, service delivery and costs.

B. Care Coordination is~~;~~ the implementation of the individualized, culturally appropriate comprehensive care management plan through appropriate linkages, referrals, coordination and follow-up to needed services and supports. Developed in active partnership with the member and the member's family, as appropriate, promotes integration and cooperation among service providers and reinforces treatment strategies that support the member's motivation to better understand and actively self-manage his or her health condition. Specific activities include, but are not limited to:

- Appointment scheduling;
- Conducting referrals and follow-up monitoring;
- Participating in hospital discharge processes;
- Communicating with other providers and client/family members;
- Comprehensive Transitional Care;
- Coordinating plans of care;
- Reducing hospital admissions;
- Easing the transition to long term services and supports; and
- Interrupting patterns of frequent hospital emergency department use.

Care providers collaborate with physicians, nurses, social workers, discharge planners, pharmacists, and others to continue implementation of the treatment plan with a specific focus on enhancing clients' and family members' ability to manage care and live safely in the community, and enhancing the use of proactive health promotion and ~~self management~~self-management.

C. Health Promotion~~;~~ services must include:

- Provide health education specific to an individual's chronic conditions;
- Development of self-management plans with the individual;
- Education regarding the importance of immunizations and screening for overall general health;
- Providing support for improving social networks;
- Providing health-promoting lifestyle interventions, including but not limited to: substance use prevention and/or reduction; smoking prevention and cessation; nutritional counseling, obesity reduction and prevention and increasing physical activity; and
- Reinforce strategies that support the member's motivation to better understand and actively self-manage her or his chronic health condition.

D. Individual and Family Support~~;~~ services must include, but are not limited to:

- Navigating the health care system to access needed services;
- Assisting with obtaining and adhering to medications and other prescribed treatments;
- Identifying resources for individuals to support them in attaining their highest level of health and functioning in their families and in their community; and
- Arranging for transportation to medically necessary services.

E. Referral to Community and Social Support Services~~; services~~ must include:

- Identifying available community-based resources; and\
- Actively manage appropriate referrals and access to care, engagement with other community and social supports, and follow-up post-engagement;
    - Common linkages could include continuation of healthcare benefits, eligibility, disability benefits, housing, legal services, educational supports, employment supports, and other personal needs consistent with recovery goals and the treatment plan.

Health Home Payment Methodology:

- An enhanced payment methodology for Health Homes must be standardized between all contracted MCOs.
- Per member per month (PMPM) payment will be based on HSD/MAD staffing model requirements.
- PMPM payment will be made to practices that meet HSD/MAD directed principles, standards and participation requirements.