12 PATIENT CENTERED INITIATIVES

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BROAD STANDARDS:

The Managed Care Organization (MCO) shall establish 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.

1. The MCO shall develop patient-centered, "whole person" models of care that ~~is~~ are uniform across payers and tailored to the diverse needs and capacities of primary care practices, large and small, urban, rural and frontier. The NM model should be based upon nationally accepted standards.
2. This model will be a blended model that builds upon the work that has already been ~~done~~ completed by practices that have achieved certification programs. ~~This~~ A blended model will include a pathway towards certification for those practices that do not currently have the capacity to attain certification.
3. The NM PCMH program will provide technical assistance, benchmarks and financial support to practices in order to move them along the pathway towards national recognition. Payment to NM PC~~H~~MH practices is standardized and based on level of PCMH achievement and continued evidence of quality care to patients and reduced cost. ~~New Mexico~~The NM -PCMH will include state specific goals tailored to the unique needs of communities and patients.
4. Core Components of the NM PCMH Model include:
    A. Administrative:
        a. Adopt a standard model for PCMH that includes national certification by NCQA, AAHC and the Joint Commission;
        b. Develop a "Glide Path" to certification that is open to all practices seeking PCMH status;
        c. Provide technical assistance and hands on training for practices working towards PCMH certification; and
        d. Simplify, coordinate and standardize practices across MCOs specifically: claims, prior authorizations, and other administrative processes
    B. Clinical:
        a. Improved access to care through flexible scheduling, accommodating walk-ins, utilization of telemedicine, providing after hours and weekend office hours;

b. Team-based care – provider teams ~~based in clinics~~ collaborate with community health workers, lactation consultants, public health workers, and other community members;
c. Integration/ co-location of behavioral health services– mental health and substance use - including SBIRT;
d. Include school based health centers and other non-traditional healthcare settings; and
e. Patient-centered care - engage patients in their own healthcare decisions, respect for patient values and culture and inclusion of patient care givers.
f. Coordination of care:
    i. Develop a care coordination collaborative that operates across payers at the point of care (in the healthcare office or other community location);
    ii. Prioritize communities of highest need;
    iii. Address social determinants of health i.e. housing, food, transportation, etc.;
    iv. Seamless transition between services and providers; and
    v. Integration of Public Health services – ex. Children's Medical Services (CMS) care coordination for children with special healthcare needs, Women Infants and Children (WIC), sexually transmitted infection treatment and contact tracing, etc.

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~~D.~~C. Data:
a. ~~Create a health care provider and practice database for the state~~Build provider capacity through support for evidence-based programs;
b. ~~Use data to inform the health system~~Facilitate partnerships with supporting entities such as the Primary Care Association to help develop tools for providers;
    ~~i. All payer claims data base~~
    ~~i. Health information exchange~~
    ~~i. Employ evidence based interventions~~

~~f.~~c. ~~Providers report on measures that reflect State-level health priority areas with a life course approach and utilizes health equity as a foundational lens~~Facilitate data sharing that provides optimal use of data~~e~~ for improving member outcomes; and~~.~~

~~g.~~d. Commitment to data integration and sharing information to improve collaborative efforts ~~in real time~~ to improve quality and lower costs, and to improve population health.

~~E.~~D. Payment:

a. ~~Standardize a payment approach for PCMH that includes practices that have not yet attained certification but are working on improving quality, access and other core components of PCMH~~Implement value-based purchasing strategies to promote quality and improve health care outcomes in alignment with the Centennial Care contractual requirements;

~~b. Would have a shared saving model among providers.~~

~~c.~~b. Align v~~V~~alue based payments with~~based on~~ patient healthcare outcomes and achievement of quality metrics; and

~~d.~~c. ~~Align payment models to specific kinds health care~~Standardize a payment approach for PCMH that includes practices that have not yet attained certification but are working on improving quality, access and other core components of PCMH

~~F.~~E. Specific Actions Related to Policy:

~~a. Improve reciprocity laws so that licensed professionals from other states can transfer to New Mexico easily~~

~~b.~~a. Support Tribal 638 programs to become Federally Qualified Health Centers under 330.

~~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 Medicaid-eligible individuals with chronic conditions, targeting a vulnerable population with behavioral health care needs through CareLink New Mexico Health Homes (CLNM).~~

~~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:~~

1. ~~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;~~
2. ~~Assign Care Coordination levels for each Health Home Member;~~
3. ~~Adhere to Care Coordination activities for level 2 or level 3 as set forth in the HSD Policy Manual;~~

4. 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;
5. Develop and implement policies and procedures for ongoing identification of Members who may be eligible for a higher level of care coordination;
6. Develop and implement policies and procedures for ongoing care coordination to ensure that Members receive all necessary and appropriate care;
7. Monitor and evaluate a Member's emergency room and behavioral health crisis services utilization;
8. Participate in the institutional setting's care planning process and discharge planning processes;
9. Maintain individual case files for each Member;
10. Ensure a dequate care coordination staffing requirements, including training required to perform the care coordination activities;
11. 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:

1. History & Physical
2. Individualized Service Plan
3. HRA
4. CNA
5. Functional Assessment
6. CCP
7. Emergency & Back-up Plan
8. Behavioral Health Co-Management summary notes
9. Advance Directive

The MCO will provide training to the Health Hhome providersAgencies 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, complete the Community Benefit Service Questionnaire and develop 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.

The MCO shall appoint one representative and one alternate representative to participate on the CLNM Steering Committee to help provide direction to and oversight of CLNM providers.

The MCO will sponsor the Emergency Department Information Exchange program so CLNM providers may receive real-time notifications of a Member's admission to an ED.

The MCO will collect and report on CLNM Member outcome measures identified by the CLNM steering committee.

The MCO shall assist CLNM Health Homes in developing MOUs with providers and identifying a referral network for CLNM Members.

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 HOMES CORE SERVICES:

1. Comprehensive Care Management must include:
    A. Assessment of preliminary risk conditions and health needs;
    B. Comprehensive serviceare Management pPlan 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;
    C. Assignment of health team roles and responsibilities;
    D. Development of treatment guidelines for health teams to follow across risk levels or health conditions;
    E. Oversight of the implementation of the cComprehensive service are Management pPlan which bridges treatment and wellness support across behavioral health, and primary care and social health supports;
    F. Monitor individual health status and service use throughThrough 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
    G. Development and dissemination of reports that indicate progress toward meeting outcomes for client satisfaction, health status, service delivery and costs.
2. Care Coordination is conducted by Care Coordinators with Members, identified supports, medical and behavioral health providers and community providers tothe implementation of the individualized, culturally appropriate comprehensive servicecare management plan. Care is coordinated 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 Mmember's motivation to better understand and actively self-manage his or her health condition. Specific activities include, but are not limited to:

A. Appointment scheduling;
B. Conducting referrals and follow-up monitoring;
C. Ensuring Members and their identified supports have access to medical, behavioral health, pharmacology, age-appropriate resiliency and recovery support services, and natural and community supportsParticipating in hospital discharge processes;
D. Communicating with Members, their family, other providers and teamclient/family members including a face-to-face visit to address health and safety concerns;
E. Developing self-management plans with MembersComprehensive Transitional Care;
F. Coordinating primary, specialty and transitional health care from ED, hospitals and psychiatric residential treatment facilitiesplans of care;
G. Delivering health education specific to a Member's chronic condition(s)Reducing hospital admissions;
H. Easing the transition to long term services and supports; and
I. Interrupting patterns of frequent hospital emergency department use and reducing hospital admissions.

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.

3. Prevention, Health Promotion and Disease Management services are designed to prevent and reduce health risks and provide health promoting lifestyle interventions associated with CLNM Member populations. These services address an array of health challenges including substance use prevention and/or reduction, resiliency and recovery, independent living, smoking prevention and cessation, HIV/AIDS prevention and early intervention, STD prevention and early intervention. Examples of these services must include:

A. Providinge health education specific to an individual's chronic conditions;
B. Developingment of self-management plans with the individual;
C. Providing eEducation regarding the importance of immunizations and screening for overall general health;
D. Providing support for improving social networks;
E. 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

- Reinforcinge strategies that support the Mmember's motivation to better understand and actively self-manage her or his chronic health condition;
- Use of evidence-based, evidence-informed, best emerging and/or promising practices curricula that integrate physical and behavioral health connects and meet the needs of the population served; and

F. Providing classes or counseling, which can be conducted in a group or individual setting. .

4. Individual and Family Support services reduce barriers to CLNM Members' care coordination, increase skills and engagement and improve health outcomes. Support services maymust include, but are not limited to:
   A. Navigating the health care system to access needed services;
   B. Assisting with obtaining and adhering to medications and other prescribed treatments;
   C. 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; and

   D. Enhancing the abilities of Members and their support systems to manage care and live safely in the community..
5. Referral to Community and Social Support Services help overcome access and service barriers, increase self-management skills and improve overall health. Servicesmust include but are not limited to:
   A. Identifying and partnering with community-based and tele-health resources, such as medical and behavioral health care, durable medical equipment (DME), legal services, housing, respite, education and employment supports, financial services, recovery and treatment plan goal supports, entitlements and benefits, social integration and skill building, transportation, personal needs, wellness and health promotion services, specialized support groups, substance use prevention and treatment and culturally-specific programs such as veterans' or Indian Health Services (IHS) and Tribal programavailable community-based resources; and
   B. Making referrals and providing assistance to establish and maintain a member's eligibility for services. Actively manage appropriate referrals and access to care, engagement with other community and social supports, and follow-up post-engagement;
      a. 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.

6. Comprehensive Transitional Care focuses on the movement within different levels of care, settings or situations and is bidirectional, diverting Members from levels of care such as ED services, residential treatment, inpatient hospitalization and transitioning Members to outpatient services. Services may include but are not limited to:

Supporting the use of proactive health promotion and self-management;
Participating in all discharge and transitional planning activities;
Coordinating with physicians, nurses, social workers, discharge planners, pharmacists, IHS, Tribal programs and others to continue implementing or modifying the service plan as needed;
Implementing appropriate services and supports to reduce use of hospital EDs, domestic violence and other shelters and RTC. Services should also support decreased hospital admissions and readmissions, homelessness, and involvement with State agencies such as Juvenile Justice, Protective Services and Corrections; and
Coordinating with Members as they change levels of care or providers within the same level of care to ensure timely access to subsequent services and supports.

HEALTH HOME PAYMENT METHODOLOGY:

1. An enhanced payment methodology for Health Homes must be standardized between all contracted MCOs.
2. Per member per month (PMPM) payment will be based on HSD/MAD staffing requirements and cost modeling, and will be specific to each CLNM provider requirements.
3. PMPM payment will be made to practices that meet HSD/MAD directed principles, standards and participation requirements.