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MQISSP — PROPOSED ENHANCED CARE COORDINATION ACTIVITIES

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Draft and Subject to Revision

The following table provides a set of working assumptions for the enhanced care coordination activities to implement as part of the Connecticut Medicaid Quality Improvement and Shared Savings Program (MQISSP) quality strategy. These enhanced care coordination activities would build upon the existing standardized requirements for Federally Qualified Health Center's (FQHC's) under the Health Resource and Services Administration (HRSA) standards and the Patient Centered Medical Home (PCMH) requirements recognized by either the National Committee for Quality Assurance (NCQA) or The Joint Commission's (TJC) PCMH standards for ambulatory care entities.

In order to identify enhanced care coordination activities, Mercer Government Human Services Consulting conducted research of national best practices in care coordination. Research included the evaluation of health care delivery redesign efforts that included care coordination models. States such as Alabama, Maine, Ohio, Rhode Island, Wisconsin, and Washington implemented changes to their Medicaid health care delivery systems with models of care coordination in PCMH or health home settings. Additional areas of research included the evaluation of national best practices in behavioral health (BH) and physical health (PH) integration, the provision of culturally competent services, establishing the availability and minimum education requirements for care coordinator staff, caring for children and youth with special healthcare needs (CYSHCN) and competencies in care for individuals with disabilities.

The working assumptions for the MQISSP required enhanced care coordination activities are defined as:

- **All Providers**: Indicates the activity will be required for FQHC and Advance Network participating entities.
- **Only FQHCs**: Indicates the activity will be required for all FQHC participating entities and represent the enhanced care coordination payment activities.

Category	Enhanced Care Coordination Activity Description	All Providers	FQHC Only
Behavioral Health/ Physical Health Integration	1. Employ a care coordinator with BH education, training, and/or experience.	✓	
	2. Employ a care coordinator with BH experience who serves as a member of the interdisciplinary team and has the responsibility for tracking patients, reporting adverse symptoms to the clinical team, providing patient education, supporting treatment adherence, taking action when non-adherence occurs or symptoms worsen, provide psychosocial support and referrals to BH services outside of the clinic when indicated.		✓
	3. Use standardized tools to expand BH screenings beyond depression.	✓	
	4. Promote universal screening for BH conditions across all populations, not just those traditionally identified as high-risk.	✓	

Category	Enhanced Care Coordination Activity Description	All Providers	FQHC Only
	5. Maintain a copy of the psychiatric advance directive in the patient's file.	✓	
	6. Develop Wellness Recovery Action Plans WRAPs in collaboration with the patient and family.		✓
	7. Maintain a copy of the WRAP in the patient's file.	✓	
	8. Expand the development and implementation of the care plan for transition age youth (TAY) with BH 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 BH challenges.		✓
	9. Require the use of an interdisciplinary team that includes BH specialist(s). The team has the responsibility for driving integrated PH and BH integration, to conduct interdisciplinary team case review meetings at least monthly, promote shared appointments and develop a comprehensive care plan outlining coordination of PH and BH care needs.		✓
Culturally Competent Services	10. Require annual cultural competency training for all practice staff. Cultural competency training will include the needs of individuals with disabilities.	✓	
	11. Expand the individual care plan to assess the impact culture has on health outcomes.	✓	
	12. Expand the CAHPS to include the supplemental Cultural Competency Item Set. [1]	✓	
	13. Require compliance with culturally and linguistically appropriate services standards (CLAS) as defined by the Department of Health and Human Services, Office of Minority Health.	✓	
Care Coordinator Staff Requirements: Availability	Providers select at least one of these options based on model(s) that fit their practice. — 14. Employ a full time care coordinator dedicated solely to care coordination activities.	✓	
	15. Assign care coordination activities to multiple staff within a practice. Consider adding language about a "lead care coordinator."	✓	
	16. Contract with an external agency to work with the practice to provide care coordination.	✓	
Care Coordinator Staff Requirements: Education	17. Define minimum care coordinator education and experience requirements within the MQISSP and determine if leveraging non-licensed staff such as Community Health Workers is desired.	✓	
CYSHCN: Age 0–17 years	18. Advance care planning discussions for CYSHCN. Advance care planning is not limited to CYSHCN with terminal diagnoses. It can be occur with CYSHCN with chronic health conditions, including BH conditions, which significantly impact the quality of life of the child/youth and their families.	✓	
	19. Development of advance directives for CYSHCN.	✓	
	20. Include school-related information in the health assessment and health record, such as: – An individualized education program or 504, noting any special accommodations, – Assessing patient/family need for advocacy from the provider to ensure the child's health needs are met in the school environment, – Determine how the child is doing in school and how many days have been missed due to the child's health condition, and – Document the school name and primary contact.	✓	

[1] Research indicates that states such as Texas, Maryland, and Oregon are using the CAHPS Cultural Competency Item Set in their Medicaid systems. In particular, Texas collaborated with the Office of Minority Health to added six items from the item set to the four Texas Medicaid biennial CAHPS surveys: STAR Child, CHIP, STAR Adult, and STAR+PLUS.

Category	Enhanced Care Coordination Activity Description	All Providers	FQHC Only
Competencies in Care for Individuals with Disabilities (inclusive of PH, intellectual, developmental and BH needs)	21. Expand the health assessment to include questions about durable medical equipment (DME) and DME vendor preferences, home health medical supplies, home health vendor preferences, home and vehicle modifications, prevention of wounds for individuals at risk for wounds and special physical and communication accommodations needed during medical visits.	✓	
	22. 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.	✓	
	23. Develop and require mandatory disability competency trainings to address the care of individuals with physical and intellectual disabilities.	✓	
	24. Acquire accessible equipment to address physical barriers to care (e.g., wheelchair scales, high/low exam tables and/or transfer equipment and lifts to facilitate exams for individuals with physical disabilities).	✓	
	25. Address communication barriers to care (e.g., offer important medical information and documents in Braille or large print, implement policies to ensure services animals are permitted into an appointment). Providers may coordinate with the Medical Administrative Services Organization to obtain available materials.	✓	
	26. Expand the 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 patient with cerebral palsy who experiences spasticity or tremors during a physical examination).	✓	
Provider Report Cards	27. Evaluate and utilize provider report cards on a quarterly basis to improve quality of care.	**TBD**	**TBD**