Connecticut Department of Social Services
Making a Difference

Medicaid Quality Improvement and Shared Savings Program (MQISSP)

Proposed Care Coordination Activities

Webinar

September 15, 2015

Connecticut Department of Social Services (DSS)

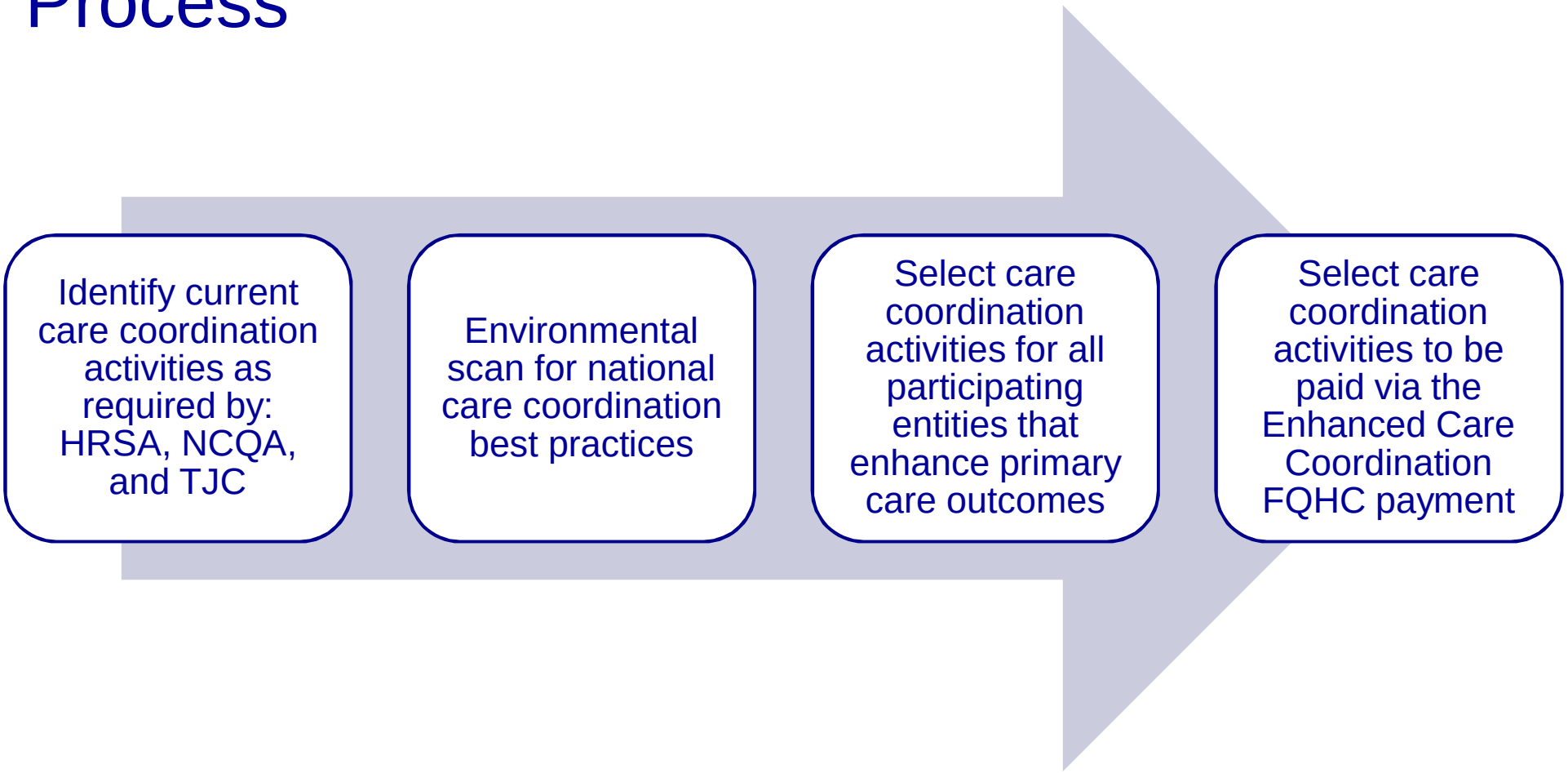
Agenda

- Introductions (DSS and Mercer)
- MQISSP Care Coordination Goals
- MQISSP Care Coordination Development Process
- Federally Qualified Health Center (FQHC) Care Coordination Activities
- MQISSP Proposed Care Coordination Activities Overview
- Next Steps

DSS MQISSP Care Coordination Goals

- Expand upon current patient-centered medical home and FQHC care coordination activities.
- Leverage national care coordination best practices.
- Identify care coordination activities required for all MQISSP participating entities (advanced networks and FQHCs).
- Identify care coordination activities required for all MQISSP participating FQHCs for Enhanced Care Coordination payment.

MQISSP Care Coordination Development Process



Enhanced Care Coordination Payment

- As a component of the MQISSP program, FQHCs will receive payment for specific care coordination activities.
- Applies to FQHC participating entities only.
- In addition to MQISSP care coordination activities required of all participating entities.

Care Coordination Activity Categories

Behavioral Health Physical Health Integration

Culturally Competent Services

Care Coordinator Staffing

Availability–Education

Caring for Children and Youth with Special Health Care Needs

Caring for Individuals with Disabilities

Behavioral Health–Physical Health Integration

Care Coordination Activity Description	All Providers	FQHC Only
1. Employ a care coordinator with behavioral health education, training, and/or experience.	✓	
2. Employ a care coordinator with behavioral health 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, and providing psychosocial support and referrals to behavioral health services outside of the clinic when indicated.		✓
3. Use standardized tools to expand behavioral health screenings beyond depression.	✓	
4. Promote universal screening for behavioral health conditions across all populations, not just those traditionally identified as high risk.	✓	

Behavioral Health–Physical Health Integration

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 in collaboration with the patient and family.		✓
7. Maintain a copy of the Wellness Recovery Action Plan in the patient's file. *	✓	
8. Expand the development and implementation of the care plan for transition-age youth (ages12–17 years) with behavioral health challenges (e.g., Collaborative activities to achieve success in transition and/or referrals to and coordination with programs specializing in the care of transition-age youth with behavioral health challenges.)		✓
9. Require the use of an interdisciplinary team that includes behavioral health specialist(s). The team has the responsibility for driving integrated physical health and behavioral health integration, to conduct interdisciplinary team case review meetings at least monthly, promote shared appointments, and develop a comprehensive care plan outlining coordination of physical health and behavioral health care needs.		✓

*See Appendix for descriptions of psychiatric advance directives and Wellness Recovery Action Plans

Culturally Competent Services

Care Coordination Activity Description	All Providers	FQHC Only
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 Consumer Assessment of Health Care Providers and Systems to include the supplemental Cultural Competency Item set.	✓	
13. Require compliance with Culturally and Linguistically Appropriate Services standards as defined by the Department of Health and Human Services, Office of Minority Health.	✓	

Care Coordinator Staff Requirements

Care Coordination Activity Description	All Providers	FQHC Only
Availability (Providers select at least one option)		
14. Employ a full-time care coordinator dedicated solely to care coordination activities.	✓	
15. Assign care coordination activities to multiple staff within a practice.	✓	
16. Contract with an external agency to work with the practice to provide care coordination.	✓	
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.	✓	

Care for Children and Youth with Special Health Care Needs: Ages 0–17 Years

Care Coordination Activity Description	All Providers	FQHC Only
18. Advance care planning discussions for children and youth with special health care needs.	✓	
19. Develop advanced directives for children and youth with special health care needs.	✓	
20. Include school-related information in the health assessment and health record, such as: **– An individualized education program or 504 plan, 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.** **– Document the school name and primary contact.**	✓	

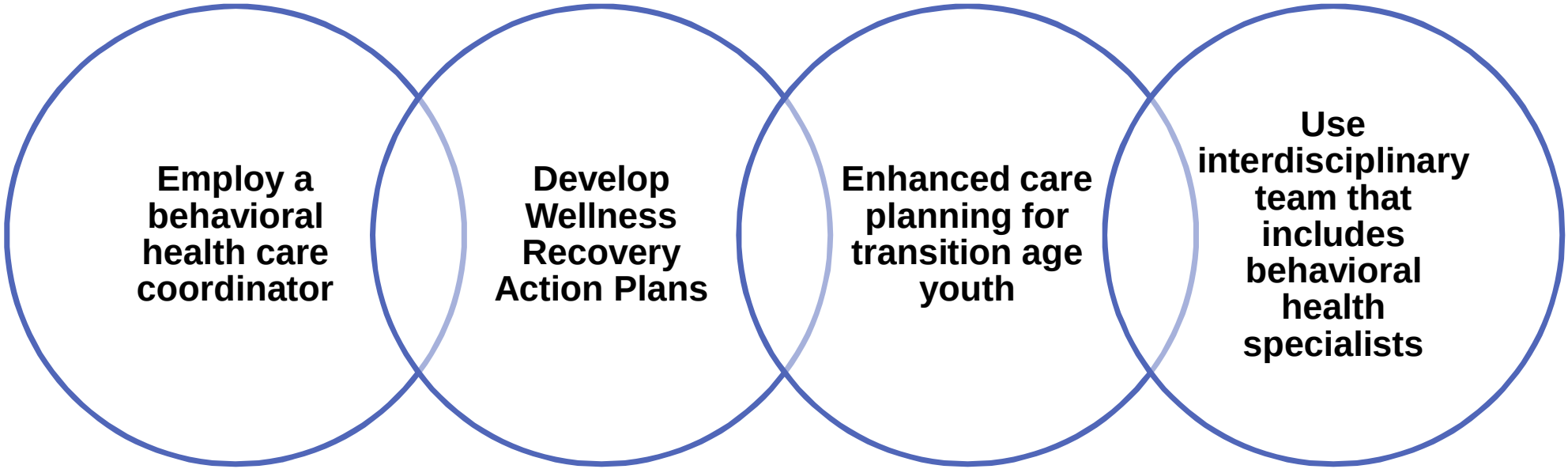
Competencies for Individuals with Disabilities

Care Coordination Activity Description	All Providers	FQHC Only
21. Expand the health assessment to include questions about durable medical equipment, 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.	✓	

Competencies for Individuals with Disabilities

Care Coordination Activity Description	All Providers	FQHC Only
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 service 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).	✓	

FQHC Enhanced Care Coordination Required Activities: Summary



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Next Steps

Submit comments and feedback to:

Kate McEvoy

Director, Division of Health Services

Connecticut Department of Social Services

Kate.McEvoy@ct.gov

DSS to incorporate feedback and finalize care coordination selections.

Appendix

What is a Wellness Action Recovery Plan?

- Evidenced-based practice for children and adults supported by the Substance Abuse and Mental Health Services Administration.
- Guides an individual to identify and implement key concepts of recovery (hope, personal responsibility, education, self-advocacy and support) to utilize in their day-to-day lives.
- Developed in collaboration with the individual and care team members of their choosing (on a 1:1 basis or as part of a workshop). Team members can include, but are not limited to, a behavioral health professional, family members, friends, and/or peers.

What is an advanced directive?

- A document that describes an individual's mental health treatment preferences or names an agent to make treatment decisions if the person becomes unable to make such decisions due to mental health issues.
- Helps a provider to plan for the possibility that someone may lose capacity to give or withhold informed consent to treatment during acute mental health episodes.
- Developed in collaboration with a behavioral health professional.