



Council on Medical Assistance Program Oversight Care Management (PCCM/PCMH) Committee

Legislative Office Building Room 3000, Hartford CT 06106
(860) 240-0321 Info Line (860) 240-8329 FAX (860) 240-5306
www.cga.ct.gov/med/

*Co-Chairs: Rep. Michelle Cook & Rep. Charlie Stallworth
May 14, 2013 Summary LOB Room 2A*

Attendance: Tiffany Huntoon, Jean Nizen , Laura Demyer, Debbie Amato, Annie Jacob, Kara Rodriguez, Erica Garcia, Judi Jordan, Jesse White Frese, Rep. Charlie Stallworth, Rep.

Michelle Cook

Rep. Michelle Cook opened the meeting at 10:00 AM.

There were introductions of the committee members.

DSS Report- Erica Garcia reported the PCMH Participation Status. Deb Amato and Kara Rodriguez gave an update on the recruitment status.

- **59 PCMH Program Participants**
 - **253 Individual Sites – 914 PCPs.**
 - ✓ 19 PCMH Approved Practices
 - 97 Sites
 - 388 PCMH Approved Providers
 - ✓ 1 Practice is Pending PCMH Approval
 - 8 Sites
 - 41 Providers Pending Approval
 - ✓ 25 Glide Path Practice Participants
 - 49 Sites
 - 162 Glide Path Providers
 - ✓ 14 PCMH Accreditation - Eligible Participants
 - 99 Sites
 - 364 PCMH Providers
 - ✓ 3 Specific Provider settings in FQHCs
 - ✓ 1 set of standards – NCQA.
 - **PCMH Glide Path Status**
 - **25 Current Glide Path Practice Participants**
 - **49 Total Practice Sites:**

- 8 Practices Currently in Phase 1
- 8 Practices Currently in Phase 2
- 6 Practices Currently in Phase 3
- 3 Practices Pending Acceptance into Glide Path
- **PCMH and Glide Path Activity:**
 - 9 New PCMH Program Participants
 - 2 New PCMH Approved Practices
 - 7 New Glide Path Practices- Private Practices
 - 7 Practices Advanced from Phase 1 to Phase 2- Shows Progress
 - 4 Practices Advanced from Phase 2 to Phase 3- 11 Advanced
 - 3 Practices Have Requested an Extension of Phase 1
 - 1 Practice Has Requested an Extension of Phase 2
- **PCMH Recruitment Status- Deb Amato Gave an Update on the Recruitment Status.**
- **215 Practices contacted since 1/1/12:**
 - 88 prospective practices in open status
 - 38 practices on a Watch-List
 - 30 practices on a Closed-List
 - Practices with Closed Status are searching for working on getting an EHR.
 - They Follow up on the Watch-list.
- **EHR Status of 88 practices in open status:**
 - 58 practices (65%) have live EHRs, purchased or are implementing an EHR
 - 7 practices (8%) are searching for an EHR
 - 3 practices (3%) have no EHR
 - 20 practices (24%) the EHR status is unknown at this time
- **PCMH Recruitment Status - continued**
- **Recruitment Methods:**
 - Original recruitment work list was revenue based- Highest Claims Paid.
 - Supplemental recruitment work list is based on attribution volume at the practice level
 - New Haven and Hartford have been successful in bring the practices.
 - **Question:** Practices on the Closed List- Is it Geographic?- CHNCT will come back with an answer. CHNCT will send a copy of the Open and Closed List to Committee.
- **Promising prospects in the near future:**
 - Family Practice and Internal Medicine (New Haven County)
 - Jackson Maille, MD – Equal Health Care (New Haven County)
 - Santo Buccheri, MD - Prime Care (Hartford County)
 - St. Francis Medical Center Clinics (Hartford County)
 - The Pediatric Care Center - Dr. S. Adeyinka (Hartford County)
 - West Haven Medical Group (New Haven County)
- **The Joint Commission Update**
- **January 2013** - DSS announced its intent to provide technical assistance with The Joint Commission (TJC) to members of the Council on Medical Assistance Program Oversight
- The following workgroups were assembled:
 - ✓ **A weekly DSS and ASO meeting**
 - ✓ **The ASO TJC Task Force reviewed the Ambulatory Care Accreditation and PCMH Certification requirements**
 - ✓ **A Joint Commission Program Development Workgroup was assembled**
- **February 2013** - a program design proposal was submitted to DSS by the Medical ASO
- **March 2013** - DSS accepted the proposal and determined the TJC program design would be a third option incorporated into the existing PCMH program for eligible participants.
- The Joint Commission Update**
- Benefits for participating in the TJC option have been determined

- All eligible PCMH program participants have been identified
- Extensive research has been conducted in relation to the TJC requirements
- A consultant firm has been hired to provide onsite and telephonic education to the CPTS team as well as conduct a full document review of related PCMH program content
- A CPTS team member is in the process of working with an FQHC that is preparing for an on-site survey that will be conducted by TJC
- Agreement with care elements. There was discussion about NCQA screen shots and Reports.
- Joint Commission focuses on team building and class recognition.
- There is a tool on what they are looking for and too different types of survey.
- Rep. Cook commented on how it helps practices not have that fear.
- Jesse White Frese comments on how it is meant with team building and class recognition.
- Laura Deymer Commented on how NCQA is focused on PCMH document of process and policy. JC focused on process and want to see process in action. They focus on patient safety and quality.

Community Support Services Program Presentation by Tiffany Huntoon Manager, Community Support Services Program

Philosophy and Goals

Patient-Centered

- Assist patients in meeting their basic life necessities
- Help patients identify and access resources within the community
- Utilize a wraparound approach, encourage information sharing and treat all participants with dignity and respect
- Empower patients to reduce barriers to maintaining a healthy lifestyle
- Encourage patients to be active participants in their own plans of care

What does a Human Services Specialist do?

- Empowers members to improve their healthcare
- Addresses barriers and assists in resolve
- Collaborates with all participants coordinating the member's care
- Refers to community organizations and providers
- Attends statewide collaborative meetings
- Acts as a liaison to ensure successful engagement
- Assists in Identifying Natural Supports
- Identifies existing connections and relationships
- Builds new relationships
- Encourages Self Advocacy
- Teaches basic life skills
- Empowers and supports throughout the process
- She discussed how it is a wrap- around services and support system. Patient centered meet their basic lower level needs first
- Active participants in their plan of care.
- Bilingual.

Program Structure

- Hybrid Model of Care Coordination
 - Face-to-face home visits
 - Face-to-face community visits
 - Telephonic intervention
- Individualized Services Provided: "Meet Members Where They Are"
- Conduct intakes that assess:
 - Social Service and community resource needs
 - Emotional and behavioral health care needs

- Physical health care needs
- Resources are Provided to Alleviate Barriers
- Local and accessible
- Culturally- and linguistically-appropriate
- Free Service- Update providers.
- How many people there are in contact with- 1400 people? 300 Referrals – 180 of those are successful.
- Population mainly dealing with is Families and single homeless adults.
- 12 Statewide areas.

Community Resource Assistance

- Housing
- Food
- Clothing
- Utility Assistance
- Childcare
- Behavioral Health Services
- Dental Services
- State Benefits
- Disability Services
- Employment Services
- Parenting Supports
- Holiday Supports
- Educational Supports
- Youth Programs
- Cancer Supports
- Domestic Violence Supports
- Legal Services
- Vision Services

Early Identification: Children Ages Birth to 5 ½

- Ages and Stages Questionnaires provide the opportunity to assess and identify children with developmental and/or behavioral concerns
- Utilized as an early identification tool

Ages and Stages

Screen Five Major Developmental Areas:

- Communication
- Gross Motor Skills
- Fine Motor Skills
- Problem Solving
- Personal-Social

Risk Factors Associated with Poor Developmental Outcomes

Medical:

- Low birth weight
- Prematurity
- Seizures
- Serious illnesses

Environmental:

- Poverty
- Parents with cognitive impairments
- History of abuse/neglect
- Teenage parents

Referrals Based on Ages and Stages Questionnaire Results

- CT Birth to Three Program
- Nurturing Families Network
- Child Development Info-line
- Pediatrician and Family Doctors
- ICM RN at the ASO

Key Points:

- Care Coordination is essential
- Duplication of services is avoided

Program Follow Up

- Continued Availability for Ongoing Support
 - Members are encouraged to contact Human Services Specialists any time they are facing barriers
- Post-Intervention Assessment
 - Conducted 90 days after face-to-face visit or telephonic contact
 - Assure successful connections were made
 - Address new or unmet needs
- Satisfaction Surveys
 - Provided after face-to-face visits and telephonic contact
 - Assure quality of services

Case Example

Background

- 3 Year Old Male with Short Gut Syndrome and a feeding tube.
- Family was from Africa and spoke little English.
- Parents moved to the United States and were both unemployed and struggling to pay their rent so they were in the process of an eviction.
- Mother had to stay home to take care of ill son and Father could not find employment.

Intervention

- Human Services Specialist helped the family make an appointment with Community Mediation for Rental Assistance and also connected them with food pantries, clothing banks, and employment services.

Outcome

- Father was able to find employment, the family was utilizing the local food pantries, obtained clothing donations, and they received assistance with their rent.
- The family is now able to sustain themselves within their community.

Provider Outreach and Collaboration

- **Statewide Outreach Presentations**
 - On-Site Collaboration with Providers to Ensure Access to Community Support Services
 - Direct Referrals from Providers
 - Establish Open Lines of Communication Regarding Patient Needs
 - Continual Updates Provided to Enhance Care Coordination

Supporting Person-Centered Medical Home

NCQA Standard 4: Provide Self-Care Support and Community Resources

4A: Support Self-Care Process

4B: Referrals to Community Resources

National Quality Strategy: Triple Aim

- Promote Access
- Reign in Cost
- Achieve Quality

Contact Information

Manager of Community Support Services

Tiffany Huntoon, MBA

1.800.859.9889, ext. 4102

thuntoon@chnct.org

For more information about Health Services, please visit the HUSKY Health Website:

www.huskyhealthct.org

**Toll-Free:
1.800.859.9889**

**Fax:
1.203.265.7948**

- Rep. Cook thanked her for her presentation and work.
- Question: Are any SBHX not FQHC sponsored. Any in Glidepath?
- Child and Family Agency, integrated health Service and need to be connect to parent entity program. Cornell Hill Health having NCQA visit change focus of the New Haven.

Meeting ends at 11:30.

Next Care Management Committee is July 17, 2013 AM in LOB Room 2A.