

Care Management PCMH Committee

Person-Centered Medical Home
November 18, 2015

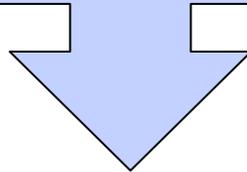


PCMH Program Status Update

***101 PCMH Program Participants**

365 Sites

1,335 Providers



70 PCMH Approved Practices

Recognized at
NCQA Level 2 or Level 3

19 Glide Path Practices

Working towards
NCQA recognition

14 PCMH Accredited Practices

Includes FQHCs

*** Please Note: 2 Practices have sites in both PCMH & Glide Path Programs**

PCMH Program Status Update

70 PCMH Approved Practices

69 last reported – September 9, 2015

1 practice voluntarily termed

2 new practices

234 PCMH Approved Sites

231 last reported

5 added

2 termed

839 PCMH Approved Providers

831 last reported

22 added

14 termed

PCMH Program Status Update

19 Glide Path Practices

17 last reported – September 9, 2015
1 practice voluntarily termed
3 new practices

28 Glide Path Sites

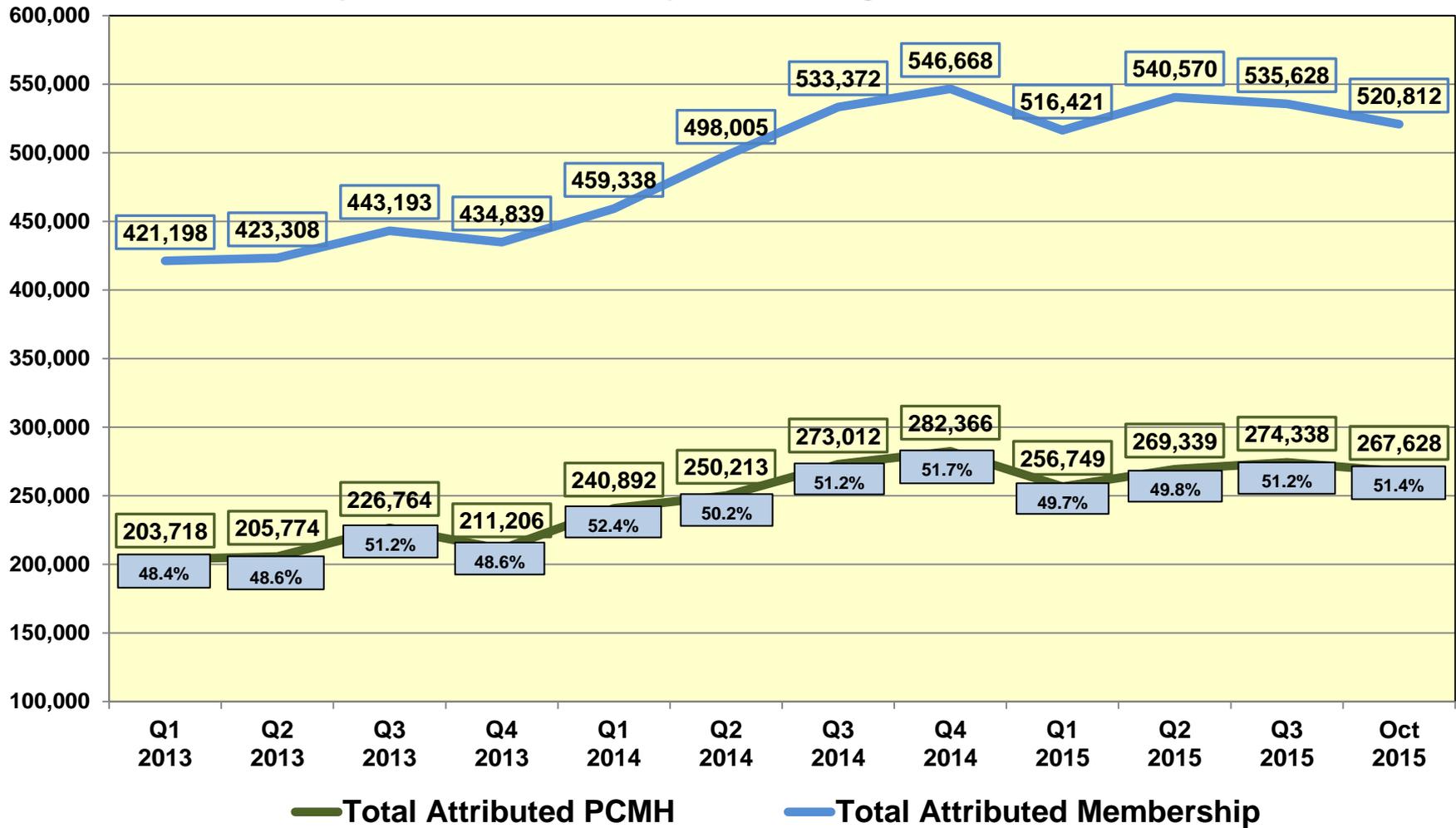
23 last reported
6 added
1 termed

121 Glide Path Providers

93 last reported
30 added
2 termed

PCMH Program Status Update

Total PCMH Attributed Members Vs Overall Total Attributed Members
By Quarter from January/2013 through October/2015



PCMH Recruitment Status Update

- Recruitment effort continues to yield results
 - Contacted since 1/1/2012 = 324 practices
 - Newly enrolled as of 1/1/2015 = 16 practices
 - Currently enrolled = 101 practices
 - Possible recruitment opportunities = 94 practices
 - 62 open practices (“Hot” & “Actively Engaged” Prospects)
 - 32 watch-list practices (“Tentative” Prospects)
 - Open practices with EHRs = 56 practices or 90%

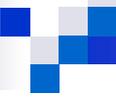


Person-Centered Medical Home Accreditation Program

&

Care Coordination Initiatives

Featured Presentation



PCMH Accreditation Program

Hospital outpatient clinics, Federally Qualified Health Centers (FQHCs) including the new Health Centers are able to participate in the DSS PCMH program and become practice participants if they are:

- Pursuing and/or have obtained the Joint Commission Ambulatory Care accreditation with or without the Primary Care Medical Home certification
- Pursuing and/or recognized as a medical home by NCQA at Levels 1, 2, or 3
- A non-standard practice (e.g. School Base Health Center or Homeless Shelter) of parent entities that are PCMH accreditation participants

Note: A detailed policy reference is provided at the end of the presentation

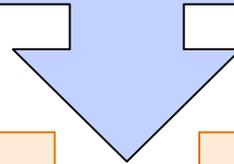
Count	PCMH Accredited Practice Participants	# of Sites	NCQA Level 3 Recognition	NCQA Level 2 Recognition	Pursuing NCQA	TJC Ambulatory Care Accredited	TJC PCMH Certified	Pursuing TJC
1	Charter Oak Family Health Center - Main Site 21 Grand Street, Hartford, CT	1	✓			✓		
	Charter Oak Family Health Center; 1 Satellite Clinic, 9 Homeless Shelters, 1 Mobile Van, 1 SBHC	12				✓		
2	Community Health & Wellness Center of Greater Torrington	1	✓					
3	Community Health Center, Inc. 11 Standard Sites	11	✓			✓	✓	
	Community Health Center, Inc. Waterbury Site	1		✓		✓	✓	
	Community Health Center, Inc. 12 SBHC's	12				✓	✓	
4	Community Health Services, Inc. Hartford, CT	2				✓	✓	
5	Cornell Scott-Hill Health Center	4				✓	✓	
6	CT Institute for Communities, Inc. (CIFC-Danbury)	1	✓					
7	Fair Haven Community Health Center, New Haven, CT Main Site	1	✓			✓	✓	
	Fair Haven Community Health Center, New Haven, CT 1 Satellite Clinic, 5 SBHC's	6				✓	✓	
8	First Choice Community Health Center, Inc.	5			✓			✓
9	Generations Family Health Center, Inc. 4 Standard Sites & 1 SBHC	5		✓		✓		
10	Norwalk Community Health Center, Norwalk, CT	1		✓				
11	Optimus Health Care, Inc., Park City Primary Care Center, Bridgeport, CT	1	✓			✓	✓	
	Optimus Health Care, Inc. 9 Standard Sites, 7 SBHC's, 1 Hospital OutPt Clinic & 1 Homeless Shelter	18				✓	✓	
12	Southwest Community Health Center, Inc., Bridgeport, CT 3 Standard Sites, 6 SBHC's and 7 Homeless Shelters	16				✓	✓	
13	Staywell Health Care Center - Corporate/Main Site 80 Phoenix Avenue, Waterbury, CT	1	✓					
	Staywell Health Care Center - 1302 South Main St., Waterbury, CT	1			✓			
14	United Community & Family Services; Norwich, Jewett City & Moosup	3	✓					

PCMH Accreditation Program

14 PCMH Accredited Practices

103 Practice Sites

375 Providers



NCQA Level 3

***8 Practices**

20 Sites (19.42%)

188 Providers (50.13%)

NCQA Level 2

***3 Practices**

7 Sites (6.8%)

34 Providers (9.07%)

Practices Not Currently Recognized by NCQA

4 Practices

76 Sites (73.78%)

153 Providers (40.8%)

*** Please Note: 1 Practice has sites in both categories**

PCMH Accreditation Program

14 PCMH Accredited Practices
103 Practice Sites
375 Providers

**The Joint Commission
Ambulatory Care Accreditation Only**

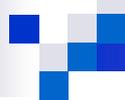
2 Practices (14.28%)
18 Sites (17.48%)
43 Providers (11.47%)

**The Joint Commission
Ambulatory Care Accreditation and
Primary Care Medical Home Certification**

6 Practices (42.86%)
72 Sites (69.9%)
257 Providers (68.53%)

Practices Not Recognized by The Joint Commission

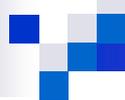
6 Practices (42.86%)
13 Sites (12.62%)
75 Providers (20.00%)



Care Coordination

**Agency for Healthcare Research and Quality
(AHRQ) defines Care Coordination as:**

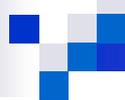
“The deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient’s care to facilitate the appropriate delivery of health care services.”



Practice Care Coordination (PCC) Team

As a component of the PCMH Program, PCC aids fourteen (14) FQHC practices with eleven (11) staff members to:

- Assist the FQHCs with their chronic and preventative care initiatives as required by NCQA PCMH Recognition
- Identify members that have gaps in recommended care and outreach to make appointments
- Support members with transportation and any needed services as identified through a specifically developed “Health Risk Questionnaire”

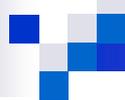


Practice Care Coordination Team (cont.)

- Utilize billing claims reports and real time FQHC EHR data to identify members in need of targeted services
- Assist members that do not have an established PCP to make an appointment
- Help to connect members to PCP after a hospitalization or transition of care
- Send “Get in Touch” letters to members that are difficult to reach, which has proven success as another way to engage members

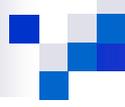
Practice Care Coordination Team Benefits

- Enhances practice clinical staff relationships with CHNCT departments to facilitate and coordinate care for members:
 - Intensive Care Management – ICM
 - Intensive Discharge Case Management – IDCM
 - Transitional Care - TC
- Increases members knowledge on the importance of establishing a relationship with a PCP
- Provides additional staffing and resources to the FQHC, focusing on the member with the intent of closing gaps in care and reducing no show rates
- Impacts overall health outcomes and costs



PCMH Program Practice Support for Care Coordination

- Members receive assistance in care coordination with PCC staff embedded in their assigned FQHC(s) who outreach and work towards closing gaps in care
- Providers receive technical assistance from CPTS staff and analytic support, such as member claims reports, to assist their PCMH teams to close gaps in care

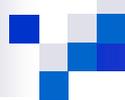


Community Health Workers

- Effective Dec 1, 2015, under the purview of the ICM program, Human Service Specialist (HSS) staff are transitioning to the role of Community Health Worker (CHW)
- CHW staff will begin comprehensive training in December
- Goals of the CHW are to help members and/or families:
 - Reduce barriers to accessing care
 - Learn to navigate and access community services and other resources leading to healthy behaviors

Community Health Workers (cont.)

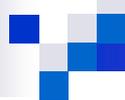
- Members are referred to CHW staff by ICM Nurses via the CHW Health Risk Questionnaire (HRQ).
- Barriers to ICM services (i.e., no response to ICM outreach) are identified through the HRQ which informs specific condition needs such as:
 - Diabetic without access to routine appointments
 - Member unable to manage asthma triggers
 - First time mother
- Interventions the CHW may take include:
 - Educate the member on how to access the transportation benefit
 - Review how to manage asthma triggers in the home
 - Facilitate access to WIC and infant resources (clothes, crib, etc.)



Community Health Workers (cont.)

The CHW:

- Provides social support, community based outreach, advocacy, culturally based education, health promotion, and referrals to services for individuals and families enrolled in HUSKY Health
- Increases the member's capacity to address health and social issues and to become active participants in working toward care plan goals
- Partners with medical providers, primary care teams, and other agencies involved in improving health outcomes for members



Community Health Workers (cont.)

The CHW also:

- Partners with CHNCT staff to coordinate and support the member through the healthcare continuum
- Cultivates and maintains awareness of community cultures and values
- Provides culturally and linguistically appropriate education, and referrals to community resources
- Collaborates with internal and external constituents, participates in health promotions and outreach activities in the community

PCMH Program Practice Support for Care Coordination

Care Coordination Team Efforts:

- ❑ Community Practice Transformation Specialists
- ❑ Practice Care Coordinators
- ❑ Intensive Care Managers
- ❑ Community Health Workers

Health Quality Measures Results:

- ❑ Antidepressant Medication Management - Acute & Continuation Phases
- ❑ Asthma Related ED Visits
- ❑ ED Visits
- ❑ Readmissions within 30 Days
- ❑ Cholesterol Management for Cardiovascular Conditions
- ❑ Comprehensive Diabetes Care
- ❑ Well Care

Measure Results Relating to Care Coordination - CY2013

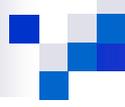
Administrative Measures	Measure Rates – by Settings Category					
	Overall	PCMH - Non FQHC	Glide Path Non-FQHC	FQHC	Practice with No PCMH	Members not Attributed
Antidepressant Medication Management - Acute Phase	61.8%	63.9%	65.1%	59.7%	61.8%	57.0%
Antidepressant Medication Management - Continuation Phase	46.8%	47.8%	48.7%	44.4%	47.3%	39.0%
Asthma Patients with One or More Asthma-Related Emergency Room Visits <i>(Lower rate indicates better results)</i>	12.0%	8.7%	11.0%	13.9%	10.7%	16.3%
Ambulatory Care-ED Visit per 1000 Member Months <i>(Lower rate indicates better results)</i>	78.7	68.5	67.8	106.3	69.0	70.0
Readmission within 30 Days <i>(Lower rate indicates better results)</i>	12.4%	11.3%	8.4%	14.2%	12.2%	12.0%
Cholesterol Management for Patients With Cardiovascular Conditions - LDL Screening <i>(Hybrid measure reported with admin rate)</i>	73.5%	73.3%	71.3%	73.8%	71.3%	52.0%
Comprehensive Diabetes Care - Eye Exam <i>(Hybrid measure reported with admin rate)</i>	48.4%	54.4%	50.3%	49.2%	50.7%	40.0%
Comprehensive Diabetes Care - LDL Screening <i>(Hybrid measure reported with admin rate)</i>	67.9%	74.4%	70.8%	71.7%	67.5%	49.0%
Well-Child Visits in the First 15 Months of Life - 6 or More Visits <i>(Hybrid measure reported with admin rate)</i>	72.0%	82.8%	79.2%	67.4%	76.3%	53.0%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life <i>(Hybrid measure reported with admin rate)</i>	77.9%	84.5%	82.1%	81.3%	81.4%	49.0%
Adolescent Well Care <i>(Hybrid measure reported with admin rate)</i>	57.9%	69.3%	68.2%	63.4%	66.5%	21.0%

Note: 1) PCMH Non-FQHC includes PCMH community practices and PCMH hospital primary care clinics
 2) Glide Path Non-FQHC includes Glide Path community practices and Glide Path hospital primary care clinics
 3) Stratification includes: - Dual members excluded. Claims paid through 5/31/2014. Measure source includes HEDIS and DSS custom measures. Attribution is as of January 2014

ANY QUESTIONS?



**I HOPE YOU ENJOYED OUR
PRESENTATION**



Reference

PCMH Accreditation Policy

**Federally Qualified Health Centers
and
Hospital Outpatient Clinics**

**Person-Centered Medical Home Regulation
Sec. 17b-262-926 - 17b-262-936**

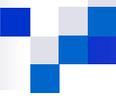
Person-Centered Medical Home Regulation

Sec. 17b-262-927 Definitions

(28) “PCMH accreditation” means the department’s process for approving a PCMH accreditation provider that meets a high standard of person-centered primary care pursuant to section 17b-262-930 of the Regulations of Connecticut State Agencies;

(29) “PCMH accreditation provider” means an FQHC or outpatient hospital clinic that seeks or has obtained PCMH accreditation pursuant to section 17b-262-930 of the Regulations of Connecticut State Agencies;

(30) “PCMH accreditation standard-setting authority” means one or more nationally recognized PCMH standard-setting organizations selected by the department as an authority whose standards apply to a PCMH accreditation provider, such as The Joint Commission (TJC), which sets standards for TJC’s Primary Care Medical Home program as part of TJC’s Ambulatory Health Care accreditation program;



Person-Centered Medical Home Regulation

Sec. 17b-262-930 Requirements for PCMH Accreditation

- (a) Eligible PCMH Accreditation Providers and Applicable PCMH Standards.
- (1) FQHCs. An FQHC may seek PCMH accreditation to receive technical assistance from the department to attain and maintain PCMH Level 1, PCMH Level 2 or PCMH Level 3 recognition from the PCMH status standard-setting authority or PCMH certification from the PCMH accreditation standard-setting authority.
 - (2) Outpatient Hospital Clinics. An outpatient hospital clinic may seek PCMH accreditation to receive technical assistance from the department if it chooses to seek and maintain PCMH certification from the PCMH accreditation standard-setting authority in lieu of seeking and maintaining PCMH status pursuant to section 17b-262-928 of the Regulations of Connecticut State Agencies.

Person-Centered Medical Home Regulation

Sec. 17b-262-930 Requirements for PCMH Accreditation

- (c) A PCMH accreditation provider shall, at the time of its application and on an ongoing basis:
- (5) In consultation with the department, prepare a gap analysis and work plan documenting the steps that a PCMH accreditation provider has taken and will take to achieve, as applicable pursuant to subsection (a) of this section, PCMH certification from the PCMH accreditation standard-setting authority or PCMH Level 1, PCMH Level 2 or PCMH Level 3 recognition from the PCMH status standard-setting authority, except that except that the department may, in its discretion, deem a non-standard practice to meet the requirements of this subdivision if the non-standard practice demonstrates that:
- (A) It provides care in accordance with a written schedule of service hours that it submits to the department for approval as part of its PCMH accreditation application and resubmits to the department for re-approval not less than fourteen days before it proposes to change such schedule; (B) **it is a satellite practice of a parent entity that is seeking PCMH accreditation in compliance with this subsection;** (C) it follows the same policies and procedures as the parent entity, including, but not limited to, using the same electronic health record system; (D) on behalf of the non-standard practice, its parent entity will provide access to care or health care advice at one or more of the parent entity's full-service practices that is seeking PCMH accreditation in compliance with this subsection, on days and hours when the non-standard practice does not provide care, seven days per week, twelve months per year; and (E) it will provide additional information in its claims for data