System of Care

Trauma-informed child and family-centered care coordination model of care, utilizing a three-tiered model that included:

(1) a Family Centered Clinical Model utilizing a wraparound approach

(2) a Quality Improvement program that relied on analyzing large data sets of key performance indicators from DSS

The InCK program will build on the two current CT Medicaid primary care initiatives, the Person Centered Medical Home (PCMH) and the PCMH Plus (PCMH+) programs and system's experience by allowing providers to access payment for enhanced care coordination payments for children and pregnant women who risk stratify to a Service Integration Level (SIL) of 2 and 3.

The American Academy of Pediatrics introduced the medical home concept in 1967. Leading primary care-oriented medical professional societies released the Joint Principles of the Patient-Centered Medical Home (PCMH) in 2007. NCQA released its PCMH Recognition program—the first evaluation program in the country based on the PCMH model—in 2008. Today, NCQA's PCMH Recognition program has evolved to feature a set of 6 concepts that make up a medical home.

PCMH

The Connecticut Department of Social Services (DSS) Person-Centered Medical Home (PCMH) program is based on the National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home model of care. Practices that implement the PCMH model provide person-centered, comprehensive, and coordinated care. Care is organized around the patient and led by a primary care provider who facilitates and coordinates a person's healthcare needs with other healthcare professionals.

As of January 1, 2012, Connecticut Medicaid ended its capitated managed care program and became self-insured and introduced a new health care delivery model, Person-Centered Medical Home (PCMH), focusing on the overall health care experience; at the core of a "person-centered" approach is the idea that the person is a partner in their delivery of care. The aim of this practice-level model is to enhance the primary care experience through coordinated care that ensures appropriateness resulting improved health outcomes while containing costs.

HUSKY Health Program | HUSKY Health Providers | PCMH | Discover PCMH (huskyhealthct.org)

NCQA STRUCTURE OF CONCEPTS, CRITERIA AND COMPETENCIES

Concepts. There are 6 concepts—the overarching themes of PCMH. To earn recognition, a practice must complete criteria in each concept area. If you are familiar with past iterations of NCQA PCMH Recognition, the concepts are equivalent to standards.
Criteria. Underlying the six concepts are criteria: activities for which a practice must demonstrate satisfactory performance to obtain NCQA PCMH Recognition. Criteria are developed from

evidence-based guidelines and best practices. A practice must pass all 40 core criteria and at least 25 credits of elective criteria across concept areas.
Get Started

NCQA PCMH Recognition: Concepts

NCQA PCMH Concept areas are over-arching themes that make up the patient-centered medical home. The American Academy of Pediatrics introduced the medical home concept in 1967. Leading primary care-oriented medical professional societies released the Joint Principles of the PCMH in 2007. NCQA released its PCMH Recognition program—the first evaluation program in the country based on the PCMH model—in 2008. Today, NCQA's PCMH Recognition program has evolved to feature a set of 6 concepts that make up a medical home.

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PROGRAM CONCEPT AREAS

- Team-Based Care and Practice Organization: Helps structure a practice's leadership, care team responsibilities and how the practice partners with patients, families and caregivers.
- Knowing and Managing Your Patients: Sets standards for data collection, medication reconciliation, evidence-based clinical decision support and other activities.
- Patient-Centered Access and Continuity: Guides practices to provide patients with convenient access to clinical advice and helps ensure continuity of care.
- Care Management and Support: Helps clinicians set up care management protocols to identify patients who need more closely-managed care.
- Care Coordination and Care Transitions: Ensures that primary and specialty care clinicians are effectively sharing information and managing patient referrals to minimize cost, confusion and inappropriate care.
- Performance Measurement and Quality Improvement: Improvement helps practices develop ways to measure performance, set goals and develop activities that will improve performance.

https://ncqa.sharepoint.com/sites/Publication_TOCs/SharedDocuments/Forms/AllItems.aspx?id=%2Fsites%2FPublication_TOCs%2FSharedDocuments%2FPCMH_SGs_TOC%2Epdf&parent=%2Fsites%2FPublication_TOCs%2FSharedDocuments&p=true&originalPath=aHR0cHM6Ly9uY3FhLnNoYXJlcG9pbnQuY29tLzpiOi9zL1B1YmxpY2F0aW9uX1RPQ3MvRWN5OTVTeFRoWnROdllVMHNTN3dZZ1lCM2JIc3dKaFlCTWJubm14VkdYdVczdz9ydGltZT1EMnZXQzRyejJFZw

PCMH±(Plus)

On January 1, 2016, the Department of Social Services launched its new, upside-only shared savings initiative entitled the Medicaid Quality Improvement and Shared Savings Program (MQISSP) which is known as PCMH+. PCMH+ aims to improve health outcomes and care experience of Medicaid beneficiaries through arrangements with competitively selected, participating providers (FQHCs and "advanced networks'') that receive care coordination payments (FQHCs only) and a portion of any savings that are achieved (FQHCs and advanced networks), on the condition that they meet benchmarks on identified quality measures.

Person-Centered Medical Home Plus (PCMH+)--Program Resources (ct.gov)

Building on Connecticut's PCMH Model, key areas of PCMH+ include:

- Integration of physical and behavioral health care
- Build on provider competencies to support members with complex medical conditions and disabilities
- Promote linkages to community supports that can assist members in maximizing their Medicaid benefits
- Promote overall health and wellness for members

Five Required Enhanced Care Coordination Activities for ALL PCMH+ Participating Entities

1. Care Coordinator:
   - Availability
   - Education

2. Behavioral Health/Physical Health (BH/PH) Integration:
   - Employment of care coordinator with BH education, training and/or experience
   - Screening
   - Psychiatric Advance Directives for Adults
   - Wellness Recovery Action Plan (WRAP) or other recovery planning tool

3. Culturally Competent Services Requirements:
   - Annual cultural competency training
   - Expanding care plan
   - CLAS standards

4. Children and Youth with Special Health Care Needs:
   - Inclusion of information in the health assessment and health information record
   - Advance care planning

5. Competencies in Care for Individuals who have Disabilities:
   - Increasing Competencies in care: Health assessment, appointment times, training, equipment, communication aids and resource list

Additional Enhanced Care Coordination ***(Activities for FQHCs only)***
Behavioral Health/Physical Health Integration

1) Care coordinator with behavioral health education, training and/or experience
2) Wellness Recovery Action Plan (WRAP) or other recovery planning tool
3) Transition Age Youth (TAY) care plans
4) Use of interdisciplinary teams

Measuring Quality

2020 PCMH Measures

Pediatric Measures (5 Measures)

- Asthma Patients with One or More Asthma-Related Emergency Room Visit(s) (Ages 2-20)
- Behavioral Health Screening (Ages 1-18)
- Developmental Screening In the First Three Years of Life
- Immunizations for Adolescents - HPV
- Medication Management for People with Asthma - Pediatric

Adult Measures (5 Measures)

- Breast Cancer Screening
- Chlamydia Screening in Women
- Comprehensive Diabetes Care - Hemoglobin A1c (HbA1c) Testing
- Post-Admission Follow-Up Within Seven Days of an Inpatient Discharge
- Use of Imaging for Low Back Pain

HUSKY Health Program | Providers PCMH | PCMH Performance-Based Payment Program Changes in 2020 (huskyhealthct.org)

PCMH± Quality Measures- Wave 3
PCMH_Wave_3_Quality_Measures.pdf (ct.gov)

(3) Community Partnerships with all physical health providers in New Haven that were integral to program implementation