MERCER
MAKE TOMORROW, TODAY

PCMH+ — ENHANCED CARE COORDINATION ACTIVITIES

The following grid presents the finalized set of enhanced coordination activities required under the Connecticut Person-Centered Medical Home – *Plus* (PCMH+) program.

PCMH+ Participating Entities (PEs) will provide Enhanced Care Coordination Activities to PCMH+ Members. The Enhanced Care Coordination Activities leverage national best practices in care coordination and exceed Federally Qualified Health Center (FQHC), HRSA and Patient-Centered Medical Home recognition requirements as defined by NCQA or ambulatory care entities with a Primary Care Medical Home certification from The Joint Commission.

- All PCMH+ Participating Entities must perform the required Enhanced Care Coordination Activities.
- PCMH+ PEs that are FQHCs will provide both the Enhanced Care Coordination Activities and Care Coordination Add-On Payment Activities, which will be reimbursed through the Care Coordination Add-On Payment.

ENHANCED CARE COORDINATION CATEGORY	ENHANCED CARE COORDINATION ACTIVITIES REQUIRED FOR BOTH FQHCS AND ADVANCED NETWORKS
Behavioral Health/Physical Health Integration	**Care Coordinator:** • Employ a care coordinator with behavioral health education, training and/or experience who participates as a member of the interdisciplinary team.

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	Screening for Behavioral Health Conditions: • Use standardized tools to expand behavioral health screenings beyond depression. PCMH+ focuses on PCMH medical primary care settings. Accordingly, it is the expectation that screening tools will be administered in the medical primary care setting. PEs are encouraged to implement screening tools in both medical and behavioral health settings as broader screening improves identification of at-risk members. • Promote universal screening for behavioral health conditions across all populations, not just those traditionally identified as high-risk. Providers are encouraged to implement screening tools in both medical and behavioral health settings.
	Psychiatric Advance Directives for Adults and Transition Age Youth: • Engage in discussions with members with behavioral health conditions about psychiatric advance directives. • If a member has a psychiatric advance directive, obtain and maintain a copy in the member's file. • If a member wishes to develop a psychiatric advance directive, provide support to the member to develop one.

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	Wellness Recovery Action Plan (WRAP) or Other Behavioral Health Recovery Planning Tool: • Engage in discussions with members with behavioral health conditions about WRAPs or other behavioral health recovery planning tools. • If a member has a WRAP or other behavioral health recovery-planning tool, obtain and maintain a copy in the member's file. • If a member wishes to develop a WRAP or other behavioral health recovery-planning tool, provide support to the member to develop one. • The WRAP is a federal Substance Abuse and Mental Health Services Administration evidenced-based practice and is used both nationally and within Connecticut's behavioral health system. However, providers may utilize alternative behavioral health recovery planning tools that meet similar objectives to WRAP. These tools should help patients develop an individualized plan with a focus on meeting individualized recovery goals. The Department of Social Services will not require the use of a specific recovery-planning tool.
Culturally Competent Services	**Training:** • Require annual cultural competency training for all practice staff. Cultural competency trainings must address the unique needs of individuals with disabilities and may be coordinated with other trainings for individuals with disabilities as outlined below.
	Care Plan: • Expand the individual care plan currently in use to include an assessment of the impact culture has on health outcomes.

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	Cultural and Linguistically Appropriate Services (CLAS) Standards: • Require compliance with CLAS standards as defined by the Department of Health and Human Services, Office of Minority Health.
Care Coordinator Staff Requirements: *Availability*	**Care Coordination Availability:** *The PCMH+ PE must provide required care coordination through individuals directly employed by, under contract to, or otherwise affiliated with the PCMH+ PE. Requirements include the following:* • Ensure care teams are easily accessible to Medicaid members, located onsite. • Effective patent care coordination requires teamwork across multiple disciplines in order to provide whole person care. PEs must ensure that community health-workers, when possible, have an expanded role to support the full integration of interdisciplinary teams across the organization. To fulfill care coordination staffing requirements, PCMH+ PEs must include one or more of the following: • Employ a full time care coordinator dedicated solely to care coordination activities • Assign care coordination activities to multiple staff within a practice. • Contract with an external agency to work with the practice to provide care coordination.

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Care Coordinator Staff Requirements: *Education*	**Care Coordinator Education:** • Define minimum care coordinator education and experience and determine if leveraging non-licensed staff such as community health workers is desired. Staff minimums can vary nationally but generally include some of the following types of staff: • Clinical and Non-Clinical Staff: – Registered Nurse – Medical Assistant – Un/Licensed Social Worker – Un/Licensed Community Health Worker – Unlicensed Health Coach – Child and Family Advocate
Children & Youth with Special Health Care Needs (CYSHCN): Age 0–17 years *The Maternal Child and Health Bureau define CYSHCN as: "Those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require*	**Advance Care Planning:** • Require advance care planning for CYSHCN. Advance care planning is not limited to CYSHCN with terminal diagnoses. It can occur with CYSHCN with chronic health conditions, including behavioral health conditions, that significantly impact the quality of life of the child/youth and his/her family. • Engage in and document in the electronic health record the discussion of advance care planning for CYSHCN. • Develop advance directives for CYSHCN.

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health and related services of a type or amount beyond that required by children generally." This definition is broad and inclusive, and it emphasizes the characteristics held in common by children with a wide range of diagnoses. Examples include children with diagnoses such as diabetes or asthma that is not well controlled.	**Health Assessment:** • Discuss the member's health assessment and document in the member's health record. • Engage in discussions with children and families about school and document school-related information in the member's health assessment and health record, such as: – The presence of an individualized education plan or 504 plan or other special accommodations in the school environment. – If the member and family need advocacy from the provider to ensure the child's health needs are met in the school environment. – How is the child doing in school and how many days have been missed due to the child's health condition. – Documentation of the school name and primary contact.
Competencies in Care for Individuals with Disabilities **(Inclusive of physical, intellectual, developmental and behavioral health needs)**	**Health Assessment:** • Expand the health assessment to include questions about: – Durable Medical Equipment (DME) and DME vendor preferences. – Home health medical supplies and home health vendor preferences. – Home and vehicle modifications. – Prevention of wounds for individuals at risk for wounds. – Special physical and communication accommodations needed during medical visits.

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	Appointment Times: • Adjust appointment times for individuals who require additional time to address physical accommodations, communication needs, and other unique needs for individuals with disabilities. • The primary care physician and other members of the interdisciplinary team may see individuals during these adjusted appointment times.
	Training: • Develop and require mandatory disability competency trainings to address the care of individuals with physical and intellectual disabilities.
	Accessibility of Office Environment: • Acquire accessible equipment to address physical barriers to care (e.g., wheelchair scales, a high/low exam table and/or transfer equipment and lifts to facilitate exams for individuals with physical disabilities). • 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 Department's medical Administrative Services Organization to obtain available materials.
	Resource List: • 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 member with cerebral palsy that experiences spasticity or tremors during a physical examination).

ENHANCED CARE COORDINATION CATEGORY	CARE COORDINATION ADD-ON PAYMENT ACTIVITIES — FQHCS ONLY
Behavioral Health/Physical Health Integration — FQHCs ONLY	**Care Coordinator:** • 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 team, providing patient education, supporting treatment adherence, taking action when non-adherence occurs or symptoms worsen, delivering psychosocial interventions, and making referrals to behavioral health services outside of the FQHC as needed.
	WRAP or Other Behavioral Health Recovery Planning Tool: • Develop WRAPs or other behavioral health recovery planning tools in collaboration with the patient and family.
	Interdisciplinary Teams: • Require the use of an interdisciplinary team that includes behavioral health specialist(s), including the required behavioral health coordinator position. • Demonstrate that the interdisciplinary team has the responsibility for driving physical and behavioral health integration, conducting interdisciplinary team case review meetings at least monthly, promoting shared appointments and developing a comprehensive care plan outlining coordination of physical and behavioral health care needs.
Transition Age Youth – FQHCs ONLY	**Transition Age Youth (TAY):** • Expand the development and implementation of the care plan for TAY (e.g., collaborative activities to achieve success in transition and/or referrals to and coordination with programs specializing in the care of TAY. TAY is defined as “individuals between the ages of 16 and 25 years. The age range for TAY can vary to include children as young as 12 years of age.” Depending on the needs of the youth served, providers may choose to expand the upper and lower age range for TAY.