Primary Care Case Management Pilot Program
Provider Advisory Group: Agenda
April 30, 2009 call
Call in: 888-395-6588, participant code 7546334

I. Program updates, including:
1. Legislative mandates about PCCM *(See Reference 1 below)*
2. Plans for expansion
3. Lunchtime conference call scheduling

II. Updates on and discussion of subcommittees' work:

1. Care Coordination (Chair: Sandi Carbonari, Franklin Medical Group / St. Mary Children's Health)
   - Definition of care coordination *(See Reference 2 below)*
   - Care plans and risk assessments (children and adults)
   - Welcome call template development
   - Developing list of resources/guidelines

2. Disease Management (Chair: Nancy Quimby, Generations Family Health Center)
   Focus on:
   - Asthma (primarily for children)
   - Diabetes (primarily for adults)
   - Obesity (to be discussed)

3. Evaluation and Data Management (Chair: Marge Berry, East Hartford Community HealthCare)
   - Monitoring of program, including care coordination and disease management
     - Claims-based data and data for provider reporting *(See Reference 3 below)*
   - Data feedback from the Department

III. Next steps

References:

Reference 1: AMENDMENT TO THE 1915(b) MEDICAID MANAGED CARE WAIVER (HUSKY A)

1. Primary Care Case Manager (PCCM) shall be operational in the Greater New Haven and Greater Hartford areas no later than January 1, 2010.
2. The Commissioner of Social Services shall commission an independent evaluation of the cost, quality, and access impacts of the PCCM programs in Waterbury and Windham by July 1, 2010 and shall submit the evaluation to the Human Services and Appropriations Committees. The Commissioner shall identify any deficiencies in the program and recommend remediation measures.
3. PCCM shall be operational in additional geographic areas that the Commissioner approves after July 15, 2010 provided: (A) the independent evaluation finds that the PCCM program is successful in containing costs and improving quality and access; and (B) an adequate number of primary care physicians (PCP's) for both children and adults have submitted applications with the Department of Social Services.
4. New PCP's shall be allowed to enroll in PCCM at any time in any geographical area where PCCM is in effect.
5. The Department of Social Services shall inform HUSKY A enrollees in approved geographic areas of the availability of PCCM to the same extent that the Department informs such enrollees of the ability to enroll in a Managed Care Organization.
6. The Department of Social Services shall report to the Human Services and Appropriations Committees on the status of the PCCM program on January 1, 2010.
7. For purposes of this amendment, "geographical area" means Hartford, New Haven, Waterbury, and Windham, and towns that are contiguous to said cities.

Reference 2: *Care coordination definition (adapted from Maternal and Child Health Bureau):*

"Care coordination is a comprehensive, dynamic, and ongoing process which involves:

- Working with the patient and family to identify strengths and needs
- Locating and accessing needed services
- Assuring that services are coordinated among programs and agencies
- Evaluating the effectiveness of service delivery in meeting patient and family needs."

Reference 3: *Potential non claims-based measures related to subcommittees' work, as discussed in 4/21/09 data & evaluation call (see minutes for details and information on claims-based data)*

a. Disease Management
    i. Asthma (measures used in Community Care of NC [NC's PCCM]):
        - Percentage of asthma patients staged
        - Percentage of asthma patients with a written Asthma Management Plan
    ii. Diabetes (clinical/outcomes):
        - Hemoglobin A1c levels - preferably twice yearly
        - Annual lipid levels
        - Blood pressure measurement at each visit
    iii. (Obesity? BMI and process measures?)

b. Care Coordination: Completion of care plan and/or risk assessment