Patient Centered Medical Home Advisory Council Recommendations

Executive Summary

A. Patient-Centered Medical Home Advisory Council

The Patient-Centered Medical Home Advisory Council (Council) was established by Act 198 of 2014. The Council is to advise the Department of Human Services (DHS) on how Pennsylvania's Medicaid program can increase the quality of care and contain costs through a Patient-Centered Medical Home model and other care delivery reforms such as medication therapy management and telemedicine.

The duties of the Council are:

1. Organizational Model: The Council shall recommend an organizational model for the patient-centered medical home system in the Commonwealth, including possible Medicaid pilot projects.
2. Standards: The Council shall recommend standards and a process to certify patient-centered medical homes based on standards developed by a number of nongovernmental accrediting entities.
3. Education and Training: The Council shall recommend education and training standards for health care professionals participating in the patient-centered medical home system.
4. Reimbursement: The Council shall recommend a reimbursement methodology and incentives for participation in the patient-centered medical home system sufficient to ensure that providers enter and continue participating in the system and to promote wellness, prevention, chronic care management, immunizations, health care management, and the use of electronic health records and other pertinent concerns. The Council shall consider all of the following:
    a. Reimbursement to promote wellness and prevention and to provide care coordination and chronic care management.
    b. Increasing the reimbursement for certain wellness and prevention services, chronic care management, and immunizations to Medicare levels.
    c. Reducing the disparities between reimbursement for specialty services and primary care services.
    d. Increasing funding for efforts to transform medical practices into patient-centered medical homes, including the use of electronic health records.
    e. Linking provider reimbursement rates to health care quality improvement measures established by the DHS.
    f. Providing reimbursement for medication reconciliation and medication therapy management service.

The Secretary of DHS appoints the members of the Council representing the following interests: family physicians; obstetricians and gynecologists; nurse practitioners; internists; pediatricians; pharmacists; hospital and health systems; Patient-Centered Medical Homes (PCMH); mental health care providers; managed care organizations; and physician's assistants. The initial meeting of the Council was

held on April 17, 2015. Monthly public meetings were held thereafter on the second Tuesday of each month, except for August and November. Consumer participation in the meetings was welcomed and their suggestions were considered. A separate forum for consumers was hosted by Project Home and the Philadelphia Health Law Project and attended by the Chief Medical Officers for Office of Medical Assistance Programs (OMAP) and Office of Mental Health and Substance Abuse Services (OMHSAS). Their recommendations are reflected in section III on Individual and Family Satisfaction.

At each meeting robust, thoughtful discussions were conducted and the recommendations that were produced reflected the consensus of the opinions of the Council members regardless of their financial feasibility.

Act 198 requires that an initial report of recommendations be presented to the Governor, the Senate and the House, and the Secretary of DHS. This document is a report of those recommendations.

B. Definition/Description/Functions of Patient-Centered Medical Home vs. Health Homes

Patient-Centered Medical Home (PCMH)

The term "medical home" was introduced in 1967 by the American Academy of Pediatrics. The concept was embraced by the World Health Organization (WHO) and the Institute of Medicine (IOM). The Chronic Care Model, developed by Ed Wagner, further promoted this model as a way to improve chronic health care.

The PCMH provides comprehensive primary care for children, youth, and adults. It is a health care setting that facilitates partnerships between patients and their personal physician and the patient's family when appropriate. Patient care focuses on the whole person, taking into account both the physical and behavioral health of the individual. Patient care is comprehensive—appropriately arranging care with other qualified professionals as needed and coordinating care through all stages of life: acute care, chronic care, preventive services, and end of life care. Care is team-based, with whole person orientation, achieved through coordinated care. The PCMH is facilitated by "high tech" interventions such as electronic medical records, health information exchanges, "virtual" telemedicine services, and patient registries as well as personal connections through community-based, peer driven support services. In addition, the PCMH must meet certain recognition or certification standards and quality measures. In return, the PCMH must be fairly compensated for the cost of providing care through fee-for-service (FFS) payments, per member per month (PMPM) payments, and embrace the move to value-based purchasing or bundled payments.

Additional information[1] on the joint principles that define the care of the patient in a medical home as outlined by the Patient Centered Primary Care Collaborative[2] and developed by the American Academy of Family Physicians, the American College of Physicians, and the American Osteopathic Association.

[1] http://www.aafp.org/dam/AAFP/documents/practice_management/pcmh/initiatives/PCMHJoint.pdf
[2] https://www.pcpcc.org/

HEALTH HOMES (HH)

A HH is different from a PCMH. A HH is grounded in Section 2703 of the Patient Protection and Affordable Care Act (ACA) and is designed for the Medicaid population.[3] It focuses more specifically on individuals with chronic conditions. The eligible population for a HH is defined as people with Medicaid who have:

- Two or more chronic conditions
- Have one chronic condition and are at risk for a second.
- Have one serious/persistent mental health condition.

Examples of people with conditions that would be areas of focus for HHs are those with mental health, substance abuse, asthma, diabetes, heart disease, and obesity. States can target health home services geographically. States cannot exclude people with both Medicare and Medicaid from HH services.

HH services include:

- Comprehensive care management
- Care coordination
- Health promotion
- Comprehensive transitional care/follow-up
- Patient/family support
- Referral to community and social support services.

HH services focus on team-based, whole-person orientation with explicit focus on integration of behavioral health and primary care.

HH's have a defined set of quality measures outlined in the ACA.

Details of the Patient-Centered Medical Home Advisory Council's Recommendations

I. Define Patient-Centered Medical Home for Medicaid Beneficiaries

A. The PCMH is a care delivery model whereby the patient treatment is coordinated through their primary care provider or clinician to ensure they receive the necessary care when and where they need it, in a manner they can understand. [4] It provides comprehensive care for children, youth, and adults. It focuses on the whole person; it is team based; it is accessible; it has a high degree of patient engagement; it respects patient choice; it provides care that is

[3] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Integrating-Care/Health-Homes/Health-Homes.html

[4] As defined by the American College of Physicians https://www.acponline.org/running_practice/delivery_and_payment_models/pcmh/understanding/what.htm)

easy for the patient to understand; and it is facilitated by high-tech interventions such as electronic medical records and information exchanges.

B. The PCMH program will be implemented through our physical health (PH) and behavioral health (BH) MCOs in high Medicaid volume practices. DHS should allow flexibility in the number of practices participating in the PCMH program, so the definition of "high volume" has yet to be determined at this time.
C. DHS should develop a common set of parameters and quality metrics that must be met in order for a PCMH to qualify for PCMH payments. Parameters will include that practices move toward accreditation or recognition as a PCMH within two years through an organization such as: National Council for Quality Assurance (NCQA), The Joint Commission (TJC), the Association of Ambulatory Health Care Ambulatory Medical Home Program, Utilization Review Accreditation Commission (URAC), Council on Accreditation (COA), and the Commission on Accreditation of Rehabilitation Facilities (CARF), or others.
D. The pediatric PCMH focuses on children, youth, and adolescents as they transition to adulthood and their special concerns: oral health, well child visits, nutritional needs, immunizations, Early and Periodic Screening, Diagnosis and Treatment (EPSDT), behavioral health, developmental concerns, special needs care planning/care integration for medically complex children, and addressing transitioning to adult-oriented systems.
E. Care coordination/integration is a key component of the model. Care integration is the "seamless provision of health care services from the perspective of the patient and the patient's family, across the entire care continuum. It results from coordinating the efforts of all providers, irrespective of institutional, departmental or community based organizational boundaries.[5]
F. Focus on population health management and prevention. The generally accepted definition of population health was defined by David Kindig, MD, PhD and Greg Stoddard, PhD, as: "…the health outcomes of a group of individuals, including the distribution of such outcomes within a group." These groups are often geographic populations such as nations or communities, but can also be other groups such as employees, ethnic groups, disabled persons, prisoners, or any other defined group.[6]
G. Engage the patient, family and other significant persons in the provision of care and consider the patient's personal health goals, life situation, and preferences.

[5] Antonelli 2014 http://www.mass.gov/anf/docs/hpc/quipp/hpc-cdpsr-antonelli-achieving-optimal-outcomes-integ-care-fcmh-models-no-photos-11-13-13-final3.pdf

[6] http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.93.3.380

II. Physical Health/Behavioral Health Integration Within the PCMH

People with mental health and Substance Use Disorder (SUD) often have co-occurring, untreated, and preventable chronic illnesses that can cause an individual to die earlier than the average person. Primary care settings are often the initial gateway to the behavioral health system since screening for mental health and SUD begins there. Integration is the "….systematic coordination of general and behavioral health care." For many individuals with Serious Persistent Mental Illness (SPMI), their primary site of care is with a behavioral health care provider. Integration can mean bringing physical health into a behavioral health setting. This allows for a comprehensive approach to caring for individuals with multiple healthcare needs.[7]

There is a continuum of levels of integration: from minimal collaboration (example: in the form of a consult) to a fully merged, transformed practice where all clinicians work together as a team.[8] The Council recommends:

A. Provide for an integrated model of care, since literature reflects that this is the most optimal model of care.
B. Allow for various models of co-location and/or integration, including a "virtual" connection. There will be a continuum of integration from consultative, co-location; to full physical integration with team based care. Co-location means that behavioral health, physical health, and other health care providers have offices in the same facility. Integration means that behavioral health, physical health and other healthcare providers not only share the same space within a facility and are seen as one provider entity, but also interact in patient care as a team, managing the physical and behavioral aspects of the PCMH's population.
C. Ensure integration models are less prescriptive in terms of organizational structure but more prescriptive of explicit design on expectations and outcomes.
D. Tie any payment, such as a per member per month (PMPM) method to the level of integration, and the complexity of patient and needed care, and amount of effort put in by care team members. A higher PMPM would apply to integration models with greater intensity of care provided: more face-to-face meeting and time spent with individuals and families.
    1. Tiered payments should reflect some type of risk adjusted payment to reflect the complexity of the patient and needed care, as well as the level of integrated care that is needed (example: consultative versus fully integrated care).
    2. Tiered payments should reflect the availability of open panel, expanded hours, or both. (i.e. Payment goes up as access increases.)

[7] http://www.integration.samhsa.gov/about-us/what-is-integrated-care
[8] http://www.chcs.org/media/ACO-LC-BH-Integration-Paper-0709141.pdf

E. Team-based care can include licensed professionals and other non-licensed team members. Examples of licensed providers include but are not limited to: physicians, dentists, dental hygienists, public health dental hygiene practitioners, physician assistants, certified registered nurse practitioners (CRNPs), nurse midwives, registered nurses, licensed practical nurses, individuals with a Masters of Social Work, dieticians, psychologists, and pharmacists. Examples of non-licensed team members include but are not limited to: medical assistants/technicians, community health workers, doulas, paramedics/emergency medical technicians, faith-based ministries, health educators, and peer specialists. The team must also include non-professionals chosen by the patient to support the patient's health goals, such as family members or friends.

F. Develop actuarial sound rates and provide oversight of the financial management of integrated payments. Integrated payment models will be implemented through the HealthChoices PH and BH MCOs.
    1. The PH and BH MCOs will be contractually required to have a uniform consistent approach, across all plans, to operationalize the PCMH program.
    2. The PH and BH MCOs will be contractually required to make payments directly to providers.

G. Develop a way to measure the level of "integrated-ness", such as shared care plans, daily team "huddles", chronic condition management, and care management. DHS will work with the MCOs to develop a consistent, standardized approach for tracking care management activities.

H. Ensure all critical communication occurs --- with schools, community partners, behavioral health partners, home care agencies, durable medical equipment providers, early intervention, and families. Care planning is essential; it needs to be coordinated with individuals or groups involved in the child's care plan. This is an extension of the "team huddle".

I. Integrate care management/care coordination and integration is vital. Parental involvement or the involvement of a patient's advocate (a person who is important to the patient) is important in the care planning process. DHS will expect the MCOs to use a consistent approach to track care management activities that focus on patient outcomes, such as using care management codes or care plan tracking systems.

J. Focus the PCMH model on care management/care coordination that includes referring to resources within community, based on the social determinants of health and individual needs. The PCMH will connect an individual to community resources as needed so that individuals get assistance with problems such as food insecurity, housing instability, obtaining legal services, and obtaining public benefits (such as SNAP, LIHEAP).

K. Seek input from patients and families within the practice.

L. Include the availability of regional psychiatrists to offer provider to provider consults on an urgent basis. It would be important for providers to get to know the psychiatrist on the other end of the phone.
M. Include integration at all ages.
N. Ensure community partners are part of the integration model
O. Address transitions of care from inpatient to outpatient care as well as from pediatric to adult oriented systems of care.
P. Measure the outcomes of care, including process measures (e.g. huddles, care plans, number of patient touches, response times to patient inquiries, the percent of "same day" appointment access), outcomes of care using quality metrics and patient- centered metrics. DHS can build on the current provider Pay for Performance (P4P) program that has no penalties for low performance. There are quality benchmarks that reward for incremental improvements. DHS will also build on the new PH-BH Integrated Care Plan P4P and the Community Based Care Management Program. DHS will focus on aligning incentives, PMPM payments, and current and future P4P payments.
Q. Measure individual and family experience of care through validated practice level surveys.
R. Focus on health promotion, while addressing primary, secondary and tertiary levels of prevention interventions, and social determinants of health. Healthy People 2020 defines social determinants of health as: "social determinants of health are conditions in the environments in which people are born, live, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks."[9] Conditions can be social, economic, and physical. Two of the key social determinants are stable housing and access to food. An individual's basic needs must be met before he/she can focus on health issues.
S. Focus on quality improvement.
T. Align incentives and PMPM payments and current as well as future P4P payments.
U. Assess the impact of integration over time.
V. Build on the Provider P4P program, including the new PH-BH Integrated Care Plan P4P program and the Community Based Care Management Program.

III. **Individual and Family Satisfaction**

A. Individual satisfaction surveys should be short in length and written in plain language. They should include evaluation of front desk and other non-physician staff that is important in team-based care. The survey should ask questions relevant to patient engagement, such as "spends enough time with you", "did someone talk with you about your goals for health?", and "was communication

[9] http://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health

clear and easy to understand?" The survey should include shared decision making.

B. Surveys should consider evaluating the degree to which the team includes patients in care planning and coordination, the ease of access patients have to the care team and to care, and the ability of care providers to communicate with them in clear, easy to understand ways.

C. DHS will provide a menu of validated survey options for practices to implement. A validated survey tool must be used to reflect that practices are meeting patient needs. The survey tool should meet literacy standards and be written in the preferred language of patients in the Medicaid program. Practices need to demonstrate incremental improvement over time. One example of a valid practice level process tool to monitor effective process implementation could be based on the "Ask Me Three"---Did you leave understanding your diagnosis, treatment options, and what to do? Would you send someone else to this provider?

D. Data elements of a Substance Abuse and Mental Health Services Administration (SAMHSA) patient satisfaction survey were recommended by consumers.[10]

E. In addition to PCMH specific satisfaction surveys, DHS could have the MCOs over-sample the current adult and pediatric CAHPS® surveys to include member served in both PMCHs versus those not served in PCMHs. This would provide a consistent measurement tool that compares satisfaction across the entire Medicaid population served by usual care versus PCMHs.

F. A satisfaction tool that specifically addresses the family experience for children. This could include the "Pediatric Integrated Care Survey" and/or the Family Voices "Family Centered Care Assessment".

G. Greater input is needed beyond the patient surveys, whether that be the establishment of a patient advisory group for the PCMH or some other vehicle to give patients more input. PCMHs will be required to have a patient advisory group to allow for additional feedback to the practice for quality improvement and care management.

IV. Pursue Health Homes, as a component of the PCMH, for persons with SPMI, SUD, children with serious emotional disturbance (SED), and patients with two or more complex medical conditions.

A. Define Health Home: Section 2703 of the Affordable Care Act of 2010, creates optional Medicaid State Plan benefit for states to establish health homes to coordinate care for Medicaid individuals with multiple chronic conditions. It operates under a "whole-person" philosophy and integrated and coordinates all

[10] http://www.integration.samhsa.gov/Patient_Satisfaction_Survey_-_English.pdf

primary, acute, BH, and long-term services. HH are for Medicaid individuals who have either:

1. Two or more chronic conditions
2. Have one chronic condition and are at risk for a second
3. Have one serious and persistent mental health condition

Health homes require more intensive services such as comprehensive care management, care coordination, health promotion, comprehensive transitional care and follow-up, patient and family support, referral to community and social support services. Patients may graduate back to the care of their primary care physician in a PCMH.

B. Recommendation to pursue development of a HH payment methodology for persons with SPMI and SUD and children with SED.
C. DHS will work with PH and BH MCOs to implement. Care management/care coordination will be funded through a tiered PMPM.
D. The HH can primarily be located in BH, but will reside in both PH and BH arenas, with patient choice defining the location of the HH. Bi-directional communication between the HH and the individual's PCMH is desired.
E. Certified Community Behavioral Health Clinic Planning Grant: DHS will use the planning grant to define what a PA HH will look like and the methodology for operationalizing it. Use the planning grant to better define what PA Health Homes will look like.
F. SUD Health Home: Leverage coordination between licensed drug and alcohol providers and PH buprenorphine providers. Enhance care coordination between various levels of care for SUD treatment.
G. Engage the patient, family, and other significant persons in the provision of care, and consider the patient's personal health goals, life situation, and preferences.

V. Medication Therapy Management (MTM)

The definition of Medication Therapy Management as defined by the American Pharmacists Association is: "*Medication therapy management is a service or group of services that optimize therapeutic outcomes for individual patients. Medication therapy management services include medication therapy reviews, pharmacotherapy consults, anticoagulation management, immunizations, health and wellness programs, and many other clinical services. Pharmacists provide medication therapy management to help patients get the best benefits from their medications by actively managing drug therapy and by identifying, preventing, and resolving medication-related problems*."[11]

A. "*Comprehensive medication management*" is defined as "*the standard of care that ensures each patient's medications (whether they are prescription, non-prescription,*

[11] http://www.pharmacist.com/mtm

alternative, traditional, vitamins, or nutritional supplements) are individually assessed to determine that each medication is appropriate for the patient, effective for the medical condition, safe given the comorbidities and other medications being taken, and able to be taken by the patient as intended." Comprehensive medication management requires: assessment of the patient's medication-related needs; identification of the patient's medication-related problems; development of a care plan with individualized therapy goals and personalized interventions; and follow up to determine actual patient outcomes.[12]

B. Medication reconciliation is: "*The process of identifying the most accurate list of all medications the patient is taking, including name, dosage, frequency, and route, by comparing the medical record to an external list of medications obtained from a patient, hospital, or other provider*".[13] Medication reconciliation can be done by a licensed clinician other than the physician--- some examples are: a pharmacist, registered nurse, CRNP, licensed practical nurse, or medical assistant.
C. Both PH and BH MCOs will play a role in MTM: provide data, identify care gaps, and use of MCO pharmacists in a consulting role.
D. PCMH and HH will participate.
E. Consider a "virtual connection" with pharmacists as well as face-to-face and telephonic.
    1. As an embedded part of the health care team.
    2. As part of a "floating" health care team at the plan; "virtual" connection; or community retail pharmacy.
F. Pharmacists will be included in a tiered payment model of integrated care.
G. Include all pharmacists as part of the PCMH team, who have specific training or are part of the PA Pharmacists Care Network (PPCN).
H. Require all prescribers to participate in the Prescription Drug Monitoring Program.
I. Medication reconciliation should occur at all care transitions by a pharmacist and/or a trained, licensed clinician.
J. Consider multiple payment mechanisms for MTM, including a billing code for pharmacists who provide face-to-face comprehensive medication management. Consider a separate billing code for pharmacists who are part of team based care through physician referral or "virtual" consultation, especially for practices in rural areas.
K. Target MTM to patients who are complex and have the greatest possibility of being impacted.
L. For targeted/complex patients: A comprehensive medication review will be done quarterly, followed by yearly, targeted reviews of medications and adherence. Risk stratify individuals to identify the high-risk population.

[12] https://www.accp.com/docs/positions/misc/CMM%20Resource%20Guide.pdf
[13] https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/7_Medication_Reconciliation.pdf

VI. Telemedicine/Health Information Technology/Health Information Exchange

Telemedicine is defined by the World Health Organization (WHO) as: "*The delivery of health care services, where distance is a critical factor, by all health care professionals using information and communication technologies for the exchange of valid information for diagnosis, treatment and prevention of disease and injuries, research and evaluation, and for the continuing education of health care providers, all in the interests of advancing the health of individuals and their communities.*" [14]

A. Telemedicine services will be paid for and will be expected to supplement face-to-face efforts for PH and BH integration and MTM, especially in rural areas.
B. Consider expansion of telemedicine to other sites of service like acute inpatient, emergency departments, and long-term care facilities.
C. Health Information Technology (HIT)/Health Information Exchange (HIE):
    1. EHR compatibility and the ability to have integrated care plans are important. There needs to be the ability to share treatment plans between providers.
    2. Ability to "talk" with other clinicians.
    3. Data sharing via HIE to meet reporting requirements and facilitate care coordination.
    4. Confidentiality/patient consent issues need to be addressed for super-protected information.
D. Minimum requirements for Electronic Health Records (EHRs) in the PCMH:
    1. PCMHs and HHs must have an interoperable EHR per Office of the National Coordinator (ONC) standards, must demonstrate that they are linked to Health Information Organizations (HIOs) and are meaningfully using their EHRs—i.e. the PCMH is actively using its integrated EHR to develop care plans to share with the team, track quality, and share information with organizations outside the PCMH.
    2. Must have the ability to extract and report basic quality metrics within in each clinical setting.
    3. Possible requirement: Within a year to 18 months practices need to connect with their local HIO and then to the statewide HIE. PCMHs and HHs need to have their EHR connected to the HIE to ensure timely transition of care and better communication between PCMHs, HHs, hospitals, and PH and BH MCOs. This should result in a decrease of duplication of services and better coordinated care.
    4. BH providers will have separate considerations since they have not been included in the HITECH Act, but it is expected that these providers should invest in EHRs that are interoperable per ONC standards and should plan in the future to link to regional HIOs.

[14] *http://www.who.int/goe/publications/goe_telemedicine_2010.pdf*

5. The DHS and the Department of Drug and Alcohol Programs (DDAP) will develop a guidance document on health information/confidentiality issues. This document will define what can be shared from MCO to providers and between providers and the care team.

VII. Quality Metrics

A. Key metrics will focus on outcomes not processes.

B. Core set of measures for a PCMH, already used by DHS for MCO and Provider P4P:
   1. Prenatal Care in the First Trimester
   2. Frequency of Ongoing Prenatal Care: ≥ 81% of expected visits
   3. Post-partum Care
   4. Well-Child Visits
   5. Annual Dental Visit
   6. Controlling High Blood Pressure
   7. Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<9%)
   8. Reducing Potentially Preventable Admissions
   9. Payment for electronic submission of mandatory and optional measures

C. Medical homes will have the ability to select quality metrics based on the population being served. A list of optional measures will be provided so that PCMHs have the flexibility to choose measures specific to the population they serve, for example:
   1. Emergency room (ER) Utilization
   2. Breast Cancer Screening
   3. Cervical Cancer Screening
   4. Medical Assistance with Tobacco Use Cessation

D. Five quality measures that are part of the DHS's new Integrated Care Plan P4P program.
   1. Initiation and Engagement of Alcohol and other Drug Dependence Treatment (IET)
   2. Adherence to Antipsychotic Medications for Individuals with Schizophrenia
   3. Combined PH-BH Inpatient 30 Day Readmission Rate for Individuals with SPMI
   4. Combined PH-BH Inpatient Admission Utilization for Individuals with SPMI
   5. Emergency Department Utilization for SPMI

E. Other examples of optional measures:
   1. Women's Health: Post-partum Depression Screening (during and after pregnancy); Pre-conception visits; Number of long-acting reversible contraception (LARC) prescriptions; Breast feeding rates.
   2. Pediatrics: immunizations; child obesity; BH screening; depression in adolescents; developmental screening and tracking referrals; antipsychotic use in children/adolescents and SED (Severe emotional disturbance) kids

(school attendance, recidivism), post-partum depression screening, autism screening, fluoride varnish application, and the current Core Set of Children's Health Care Quality Measures for Medicaid and CHIP.

3. Pharmacy: Medication reconciliation during transitions; antipsychotic medications in children; medication adherence, tied to higher cost/disease specific conditions (HIV, Hepatitis C); communication (from health plans).
4. Transitions of Care: transition from inpatient (PH or BH) to be seen within "X" number of days. Transition from pediatric to adult oriented systems of care.
5. Opioids: Initiation and Engagement of Alcohol and other Drug Dependence Treatments HEDIS® measure.
6. BH Screening: Using validated screening tools: SBIRT; depression; drug and alcohol; developmental; suicide prevention.
7. BH: Metabolic monitoring for children and adolescents on antipsychotics.
8. Patient Experience: CAHPS® (provider/consumer survey tool); access to care (appointments and emails to physicians; individual experience of care done at the practice level. Include family experience.
9. Consider measures for out of home placement, juvenile justice, youth suicide, prevention, referral tracking.
10. After-hours access and services.
11. DHS will add population specific measures to consider.

F. <u>Core set of measures for a Health Home</u>
   1. Adult Body Mass Index (BMI) Assessment
   2. Ambulatory Care Sensitive Condition Assessment
   3. Care Transition-Transition Record Transmittal to Health Care Professional
   4. Follow-up after Hospitalization for Mental/Medical Illness
   5. Plan-All Cause Readmission (For all populations.)
   6. Screening for Clinical Depression and Follow-up Plan
   7. Initiation and Engagement of Alcohol and other Drug Dependence Treatment
   8. Controlling High Blood Pressure

G. Expanded operational access or partnerships to augment practice capacity should be incentivized especially given that right venue access is a key determinant of high performing care delivery systems. Quality metrics need to include effectiveness of care, access and availability of care, experience of care, and utilization of resources.

H. Timely, transparent, actionable, real-time utilization data from the PH and BH MCOs to the provider will be important for practices to be able to effectively manage patient care. A minimum uniform data set and reporting format (template), use across all MCOs will be required. MCOs will engage practices in understanding how to use the data.

VIII. Workforce Development

A. Resources will be needed to retrain practices to develop a team-based model of care. Existing team members will need to learn new models of care delivery and incorporating the skills of new members—i.e. community health workers, peer specialists.
B. DHS will work with academic and other partners to provide support to practices.
C. A learning network will be developed to establish and share best practices guidelines, provide continuing educational opportunities, provide case based learning, and share best practices concerning clinical operations/community care management navigation. It will be an ongoing responsibility that PCMHs will be responsible for participating in a learning network collaborative.
D. Health care teams include licensed and non-licensed personnel. Work force development should focus on training needs for both groups and training needs related to SUD, SPMI, and other chronic conditions as well.

IX. Payment Models

A. DHS will give clear prescriptive guidance to MCOs regarding allocating payments to the appropriate PCMH and Health Home.
B. New DHS contracts with MCOs will move them toward value-based payments over the next three years with increasing percentage of payments.
C. PMPM payment to participating PCMHs and HHs.
D. DHS will consider a risk adjusted PMPM that has higher payments for more complex patients.
E. Initiate a tiered payment model that includes higher payments for care management rendered by team members such as behavioral health providers and pharmacists.
F. Part of the PMPM payment to providers will be used to support activities such as: EHR upgrades, connectivity, tech support, quality tracking, patient referrals to needed services, care coordination/care management, hiring community health workers or team members to assist with care integration.
G. Health Homes would focus on higher risk patients (SPMI/SUD) and individuals living with multiple, complex PH-BH conditions. HHs will be for targeted populations and will include clinics for high-need, high-cost populations. Develop a risk adjusted model for this group. HH individuals may “graduate” back to their PCP when their condition(s) stabilize.
H. Provide an enhanced PMPM if defined quality metrics, goals, and outcomes were met.
I. MTM: Initiate a tiered payment for pharmacists as part of the health care team. Consider a payment, similar to Medicare, for pharmacists providing face-to-face or remote (virtual) services in rural areas.

J. DHS must develop a framework to evaluate the payment model based on the metrics of quality of care, utilization, outcomes, and return on investment (ROI).
K. DHS, MCOs, and providers must ensure that these new payments are not paying twice for the same service ---"double dipping". Care management/coordination must be done such that appropriate handoffs are being made and there is no redundancy in service.

ABREVIATIONS

ACO: Accountable Care Organization

BH: Behavioral Health

CAHPS Survey: Consumer Assessment of Healthcare Providers and Systems

CARF: Commission on Accreditation of Rehabilitation Facilities

CRNP: Certified Registered Nurse Practitioner

DDAP: Department of Drug and Alcohol Program

DHS: Department of Human Services

EMT: Emergency Medical Technician

EPSDT: Early Periodic Screening, Diagnosis and Treatment

HIE: Health Information Exchange

HIO: Health Information Organization

HIT: Health Information Technology

LPN: Licensed Practical Nurse

NCQA: National Committee for Quality Assurance

MCO: Managed Care Organization

MTM: Medication Therapy Management

PH: Physical Health

PMPM: Per-Member-Per-Month

PPCN: PA Pharmacists Care Network

RN: Registered Nurse

SAMHSA: Substance Abuse and Mental Health Services Administration

SED: Serious Emotional Disturbance

SPMI: Serious Persistent Mental Illness

SUD: Substance Use Disorder

TJC: The Joint Commission

URAC: Utilization Review Accreditation Commission

Levels of Integration: (Based on http://www.integration.samhsa.gov/integrated-care-models/CIHS_Framework_Final_charts.pdf

Consultative: Basic collaboration at a distance. Communication is driven by specific patient issues in form of referrals. Separate practice sites, EHRs, and responsibilities.

Co-Located: Practices may be located within the same facility but have separate offices. Collaboration is driven by the need for consultation and coordinated care plans for complex patients. There may be some face-to-face interaction.

Integrated: Collaboration occurs in a transformed, merged practice; sharing the same space within the same facility. Shared concept of team- based care, one provider entity. There is one treatment plan. Patients experience a seamless response to health care needs.