**MO HealthNet**

**Application for**

**Primary Care Health Home Provider Status**

**Beginning January 1, 2019**

**TABLE OF CONTENTS**

[Section 1. Introduction 2](#_Toc442102006)

[Section 2: Health Home Service Requirements 4](#_Toc442102007)

[Section 3. Payment 8](#_Toc442102008)

[Section 4. Application Response Requirements 9](#_Toc442102009)

[Section 5. Application Evaluation Process 9](#_Toc442102010)

**APPENDICES:**

Appendix A: General Functional Definitions of Care Coordination and Care Management Services…………………………………………………………………………………………………..11

**Appendix B: Application to be Recognized as a MO HealthNet Health Home…...............15**

# Section 1. Introduction

1. **Overview**

The Missouri Department of Social Services (DSS) seeks practice sites comprised of licensed physicians (internal medicine, pediatric, and family practice specialists), collaborating with other licensed health care professionals including nurse practitioners and physician assistants, to serve as primary care health homes for MO HealthNet participants. The health home is an alternative approach to the delivery of primary care services that offers better patient experience and better results than traditional care. The health home has many characteristics of the patient-centered medical home (PCMH), but is customized to meet the specific needs of low-income individuals with certain chronic medical conditions.

The recognized primary care organizations and clinic sites will work to continually evolve as health homes. DSS requires that all recognized health homes participate in health home transformation training (as outlined in **Section 2B**).

A clinic site is defined as the single physical location at which an organization provides health home services. Organizations that wish to have multiple clinic sites recognized as health homes may submit one application, but with separate detailed responses for each site. DSS will consider each site individually.

Organizations (and individual clinic sites) will also be required to obtain recognition or certification as medical homes by either the National Committee of Quality Assurance (NCQA), The Joint Commission, or other organization approved by MO HealthNet (see **Section 2F**).

PCHH organizations will be paid per-member-per-month (PMPM) payments for performing various PCHH activities.

1. **Health Home Qualifications (Prior to Start Date)**

In order to be recognized as a Primary Care Health Home (PCHH), organizations must, at a minimum, as of the date of application submission:

* have a substantial percentage (not less than twenty-five percent) of the patient panel enrolled in MO HealthNet or uninsured;
* provide a PCHH that is capable of overall cost effectiveness (including having a sufficient number of people eligible for enrollment in PCHH to allow for sustainable PCHH staffing at all approved clinic sites);
* have strong, engaged leadership, including the medical director, physician champion, and administration personally committed to and capable of leading the transformation process and sustaining transformed practice processes as demonstrated by the application process and agreeing to participate in education and training activities offered;
* have patient panels assigned to each primary care clinician;
* actively utilize MO HealthNet’s comprehensive electronic health record (CyberAccess) for care coordination and prescription monitoring for MO HealthNet participants;
* utilize an interoperable patient registry to  track and measure care of individuals, automate care reminders, and produce exception reports for care planning;
* meet the minimum access requirements of third-next-available appointment within 30 days and same-day urgent care, and
* have an electronic health record (EHR) system in use for at least six months prior to the beginning of health home services as its primary medical record, the ability to e-prescribe, and the capacity to generate (or support the generation of through a third party such as a data repository) clinical quality measures relevant to improving chronic illness care and prevention.

Note: Organizations whose sites are not directly connected to Missouri Primary Care Association’s DRVS system, and with no plans for subscribing to DRVS, must have access to information technology resources capable of developing and producing a monthly SQL “flat file” of required PCHH clinical data elements extracted from the clinics’ EHR that is mapped appropriately so that it can be sent to the PCHH initiative data warehouse (Note:  Data mapping and file specifications will be provided.)

1. General Application Requirements
	* Applicants must confirm that a substantial proportion of their population served includes MO HealthNet-eligible and/or uninsured patients with chronic conditions.
	* Applicants must comply with established timeframes.
2. **Application Timetable**

Unless otherwise specified, the time of day for the following events shall be between 8:00 a.m. and 4:30 p.m., Central Time (CT).

**DSS may adjust this schedule as it deems necessary.** Notification of any adjustment to the Application Timetableshall be posted at [http://dss.mo.gov/mhd/cs/health-homes/](https://webmail2007.mo.gov/OWA/redir.aspx?C=X8Em4j9ukEaDAbHEphyifpXxgD4pJtFI_Dma2caWLJt4wWHUo7ugI4f0SMD9h5PHeR1y6np31sk.&URL=http%3a%2f%2fdss.mo.gov%2fmhd%2fcs%2fhealth-homes%2f)

|  |  |  |
| --- | --- | --- |
| **1.** | Application Issued | *July 16, 2018* |
| **2.** | Deadline for Written Inquiries  | *July 31, 2018* |
| **3.** | Informational Webinar | *August 13, 2018* |
| **4.** | **Applications Due** | ***August 31, 2018*** |
| **5.** | Anticipated Practice Notification Date | *September 28, 2018* |
| **6.** | Start Date | *January 1, 2019?* |

1. **Prospective Applicant Inquiries and Webinar**

Prospective applicants may make written inquiries concerning this application until August 10, 2018 at the address listed in **Section 4.A**, or by e-mail.

Inquiries received after the deadline may be disregarded.  DSS will review inquiries received before the deadline and at its discretion prepare written responses to questions which it determines to be of general interest and that help to clarify the RFA (Request for Application).  Any written response will be posted at http://dss.mo.gov/mhd/cs/health-homes/.  Only written responses will be binding on DSS.

MO HealthNet will host a **Webinar on Monday, August 13th at 10:30 a.m.** offering further discussion and an opportunity for interested providers to gain additional information. To access the Webinar:

Click on this link for computer video: [Join WebEx meeting](https://stateofmo.webex.com/stateofmo/j.php?MTID=mcf5e63a196c6526a9c4098608c7db25c)
Meeting number (access code): 807 786 571
For audio connection, join by phone: **1-650-479-3207** Call-in toll number (US/Canada)

[Can't join the meeting?](https://collaborationhelp.cisco.com/article/WBX000029055)

# Section 2: Health Home Service Requirements

PCHH organizations will work to continually evolve as health homes by fulfilling the responsibilities delineated in Section 2. Failure to meet these responsibilities will be cause for suspension of PCHH payments and/or loss of PCHH provider status.

This section substantially describes the activities organizations/clinic sites will be required to engage in and the responsibilities they will fulfill if recognized as a PCHH provider. PCHH status is also subject to change should the CMS or DSS determine that it is necessary to change the requirements of PCHHs, or should CMS or DSS action cause the elimination of the PCHH provider type.

1. **Health Home Staffing**

PCHH organizations must maintain staffing positions and ratios as required by DSS. Required staff includes:

* Health home director - no specific degree or licensure requirements (1 FTE:2500 PCHH participants)
* Nurse care manager(s) - must be registered nurse (RN) licensed in Missouri (1 FTE:250 PCHH participants)
* Behavioral health consultant(s) - must be a licensed clinical social worker (LCSW), LMSW (under supervision), or clinical psychologist (PsyD) with either a current or provisional Missouri license (1 FTE:750 PCHH participants)
* Care coordinator(s) - no specific degree or licensure requirements (1FTE:750 PCHH participants)

MO HealthNet also requires the identification and participation of a physician champion to provide leadership and guidance for the PCHH, although there are no specific FTE requirements associated with that role.

1. **Health Home Training and Other Activities to Facilitate Practice Transformation**

DSS shall require practice organizations to participate in education and training activities to help implement their PCHH functions and activities, and to help with practice transformation. Training activities will include but not be limited to periodic MO HealthNet provider webinars (held approximately every four to six weeks), care team forums, DVDs, workshops, and web-based learning activities. Organizations will also be required to participate in quality coaching and other processes offered or made available by MO HealthNet to assist with practice transformation

1. **Internal PCHH Team Meetings**

Organizations shall convene regular internal PCHH team meetings (including physician champion and other staff as appropriate) to plan and take steps to support continual PCHH evolution.

1. **Patient Registries**

PCHH organizations shall create and maintain patient registries, using EHR software, a stand-alone registry or a third-party data repository and measures reporting system. A patient registry is a system for tracking information that DSS deems critical to the management of the health of a primary care practice’s patient population, including dates of delivered and needed services, laboratory values needed to track a chronic condition, and other measures of health status. The registry shall be used for:

* patient tracking;
* patient risk stratification;
* analysis of patient population health status and individual patient needs, and
* reporting, as specified in **Section 2-I.**, below.
1. **Mastery of the Required Health Home Core Competencies**

Approved PCHH sites shall transform how they operate in order to become a health home. Transformation entails mastery of 13 health home core competencies, defined as follows:

1. Patient/family/peer/advocate/caregiver-centeredness: This means that there is a whole patient orientation to care. Longitudinal care is delivered with transparency, individualization, recognition, respect, and an understanding of and respect for cultural and linguistic preferences.[[1]](#footnote-1) Such care also provides patients/families/ caregivers with choice in all matters and possesses an ongoing focus on consumer service, with bi-directional feedback. Organizations demonstrate a defined structure at the practice/clinic level for gaining patient, family, or caretaker advisory input into overall patient satisfaction as well as feedback/suggestions/recommendations specific to operations of the health home.
2. Multi-disciplinary team-based approach to care: A collaborative multi-disciplinary care team in which team members practice to the full extent of their license, education and training with bidirectional, effective team communication, collaboration and clear role definition.
3. Personal patient-primary care clinician relationships: Each patient has a primary care clinician relationship, even if cared for by a care team within the practice.
4. Planned visits and follow-up care: In contrast to episodic, reactive care, this manner of primary care delivery schedules routine visits and tracks patients on an ongoing basis so that the practice is informed and ready to address the patient’s needs holistically whenever the patient makes contact, and follows up with patients after encounters, as necessary.
5. Population-based tracking and analysis with patient-specific reminders: To support planned visits and follow-up care, a practice needs information tracking capacity in the form of a freestanding or EHR-based patient registry with reporting functionality to proactively identify patient and population gaps in care against evidence-based benchmarks.
6. Care coordination[[2]](#footnote-2) across settings, including referral and transition management: PCHH organizations assume responsibility for tracking and assisting patients as they move across care settings, and for coordinating services with other service providers including behavioral health, social service, and long-term support providers.
7. Integrated Clinical Care Management[[3]](#footnote-3) services focused on high-risk patients and those who are high utilizers of emergency department services and/or who have frequent hospitalizations): For the most clinically at-risk patients in a practice, the health home care team works together to determine and implement strategies to provide appropriate care management for this group of people.
8. Patient and family education: The health home care team educates patients and family members both on primary preventive care, and on self-management of chronic illness (i.e., secondary preventive care).
9. Self-management support by members of the health home care team: Extending beyond education, self-management support assists the patient and/or family/peer/advocate/caregiver with the challenges of ongoing self-management, directly and/or through referral.
10. Involvement of the patient in goal setting, action planning, problem solving and follow-up: Patient-centered primary care requires care planning and related activities focused on a patient’s specific circumstances, wishes and needs involving two-way communications and active patient involvement. The health home team also works with participants to develop care plans and set self-management goals designed to improve their health status.
11. Evidence-based care delivery, including stepped care protocols: Care should be evidence-based wherever evidence exists, and follow stepped protocols for treatment of illness.
12. Integration of quality improvement strategies and techniques: Practices should utilize the Model of Improvement emphasized by the Institute for Healthcare Improvement (Plan, Do, Study, Act) (<http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx>) to measure performance, identify opportunities for improvement including those identified during and after the health home application process, test interventions, and reassess performance.
13. Enhanced access: Another hallmark of patient-centered primary care is the availability of easy and flexible access to the PCHH Care Team, including alternatives to face-to-face visits, such as e-mail and telephone[[4]](#footnote-4) and 24 hours per day/seven days per week practice coverage.
14. **Medical Home Recognition/Certification**

By the eighteenth month following the receipt of the first PCHH payment, organizations shall submit to DSS evidence that the practice has either:

* submitted an application to NCQA that subsequently results in recognition as a Patient-Centered Medical Home under the most current NCQA standards. More information can be found at: <http://www.ncqa.org/Programs/Recognition/PatientCenteredMedicalHomePCMH.aspx>

**or**

* applied to The Joint Commission for certification as a Primary Care Medical Home under the most current standards. More information can be found at: <http://www.jointcommission.org/certification/priamry_care_medical_home_certification.aspx>.

Note: Other recognition/accreditation may also be considered acceptable on a case-by-case basis.

1. **Clinical Care Management Services**

Organizations shall provide clinical care management services, as further defined in **Appendix A**. Clinical care management entails the identification of highest-risk patients, and intensive monitoring, follow-up, and clinical management of such patients. These activities generally include frequent patient contact in the clinical setting and community environment, clinical assessment, medication review and reconciliation, communication with treating clinicians, and medication adjustment by protocol.

Each organization shall employ or contract with licensed registered nurse(s) to be nurse care manager(s), responsible for providing clinical care management services. The nurse care manager shall function as a member of each PCHH team whenever patients of that PCHH team are receiving clinical care management services.

Organizations shall ensure and document that clinical care management services' funding is used exclusively to provide clinical care management services.

1. **Hospital Care Coordination and Memorandum of Understanding**

By the third month, practices shall develop policies and procedures addressing transitional care planning; addressing notification from local hospitals, MO HealthNet Division (MHD), and managed care plans of inpatient admissions of the PCHH patients; addressing notification by MHD of emergency department visits; and maintaining a mutual awareness and collaboration with local hospitals to identify individuals seeking emergency department services that might benefit from connection with the PCHH organization, and in addition motivating hospital staff to notify the PCHH’s designated staff of such opportunities. Health home organizations are encouraged to formalize these policies and procedures in a memorandum of understanding with local hospitals when feasible.

1. **Data Reporting**

PCHH organizations shall submit to DSS or its designee the following reports, as further specified by DSS or its designee, within the time frames specified below:

* periodic reports that describe the organization’s efforts and progress to implement PCHH practices;
* monthly clinical data contained within the organization’s EHR system, patient registry or a third-party data repository (by the third month of operation);
* other reports or data, as specified by DSS.
1. **Demonstrated Evidence of Health Home Transformation**

PCHH organizations are required to demonstrate evidence of health home transformation on an ongoing basis using measures and standards established by DSS and communicated to the practices. As of the publication date of this application, DSS defines evidence of health home transformation as follows:

* demonstrated development of fundamental health home functionality at 6 months and 12 months based on an assessment process to be applied by DSS or its designee, and
* demonstrated significant improvement on clinical indicators specified by and reported to DSS or its designee.
1. **Notification of Primary Care Practice Changes**

Organizations are required to notify DSS within five working days of the following changes:

* the PCHH physician champion or administrative leadership changes;
* changes in PCHH staff (terminations, new staff, changes in FTE, etc.);
* any substantive changes in organization or site ownership or composition, including:
	+ the clinic or organization is acquired by another clinic or organization;
	+ the organization closes any of its sites or can no longer maintain PCHH services in one or more of its sites;
	+ the organization merges with another organization, and/or
	+ the organization acquires another organization or site(s). (Note: new sites that are not already approved as PCHHs cannot enroll participants and provide PCHH services until such time as MHD offers another open application period, and an application is submitted and approved for those sites.)
1. **Participation in Evaluation**

Organizations and sites shall participate in an evaluation, to be performed by a DSS-designated evaluator. Participation may entail submission of monthly clinical indicator reports, submission of periodic reports describing the organization’s transformation process, responding to surveys and requests for interviews of PCHH staff and patients. Organizations shall provide all requested information to the evaluator in a timely fashion.

# Section 3. Payment

Subject to all required federal approvals, DSS has developed the following payment structure for recognized PCHH practices. All payments are contingent on the organization meeting the requirements set forth in this application, as determined by DSS. Failure to meet such requirements is grounds for revocation of health home status and termination of payments specified within this application.

The payment methodology for PCHH organizations is in addition to existing fee-for-service payments and is described as follows:

* 1. **Clinical care management per member per month (PMPM) payment.** DSS will make payment for reimbursement of the cost of staff primarily responsible for delivery of services not covered by other reimbursement (nurse care managers, behavioral health consultants) whose duties are not otherwise reimbursable by MHD.

* 1. Payments described in **Sections 3A** will be based on DSS’ count of MO HealthNet participants enrolled in the PCHH on the last day of the month, and for whom the organization attested that a health home service was provided during the month. Only those MO HealthNet participants with two or more of the following characteristics can be enrolled in a PCHH and generate a per-member-per-month payment:
* Asthma
* Behavioral Health Conditions (any of the three below count as one condition for enrollment)
	+ Anxiety
	+ Depression
	+ Substance Use Disorder\*
* Diabetes (defined as both a chronic condition and a risk factor)
* Cardiovascular disease - including hypertension and hyperlipidemia
* Overweight (BMI 25-29 [adults] or 85th to 94th percentile [pediatrics]) and obesity (≥30 BMI [adults} or ≥95th percentile [pediatrics])
* Developmental disabilities
* Tobacco use (defined as a risk factor)

\*Organizations that want to enroll people with substance use disorder must have at least one clinical provider certified to provide medication-assisted treatment

Individuals with the following stand-alone conditions who meet utilization criteria may also be enrolled in PCHH:

* Diabetes
* Obesity (≥30 BMI [adults} or ≥95th percentile [pediatrics])
* Pediatric asthma

To provide organizations with a start-up panel of PCHH participants (managed care or fee for service), MHD will work with practices to help identify their initial eligible panel of patients. Organizations will also be able to continually identify and add participants that meet enrollment criteria. Participants are granted the option to change their health home, or to opt out of health home services, should they so desire.

Should experience reveal to DSS that elements of the payment methodology will not function, or are not functioning, as DSS intended, DSS reserves the right to make changes to the payment methodology after consultation with recognized health homes and receipt of any and all required federal approvals.

# Section 4. Application Response Requirements

1. **General Submission Instructions**

Applications must be submitted by e-mail to Mary.K.Brown@dss.mo.gov by the date and time listed in the Procurement Timetable, **Section 1D**. A follow-uphard copy of the responses must be postmarked by the due date for e-mailed responses, and sent by mail or other hand-delivery to:

Kathy Brown

ATTN:  MO HealthNet Primary Care Health Home Initiative

PO Box 6500

Jefferson City, MO  65102

1. **Contents of the Submission**

The applicant must submit:

* a completed application form, found in **Appendix B**, attached to this application, and
* **a cover letter** that clearly states the name of the applicant organization and the name of the applicant’s contact person. The letter must be signed by an individual authorized to bind the applicant.

# Section 5. Application Evaluation Process

1. **Application Review and Evaluation**

#### Compliance with Application Instructions

All responses will be reviewed by DSS to determine compliance with the response submission instructions described in **Section 4**. For those responses that comply with the response submission instructions, including meeting the pre-qualification requirements defined in **Section 1.B** and the submission of a complete response to the application contained in **Appendix B**, an Evaluation Committee designated by DSS will review the applications.

#### Applicant Interview/Site Visit

At its discretion, DSS may elect to interview or visit some or all applicants to assess their qualifications to serve as a health home.

#### Evaluation Criteria for Health Homes

* 1. The following identifies the criteria by which DSS will evaluate written responses and interview findings, if any, from each applicant organization/site:
		+ the organization (and all applicable sites) demonstrates that it meets the pre-qualifications identified in **Section 1.B**;
* each applicable clinic site has been providing clinical services for a minimum of two years;
* each applicable clinic site has at least 75 individuals identified who can be initially enrolled in the PCHH (to facilitate staffing);
* the quality of the responses to the questions in **Appendix B** in accordance with the following criteria: comprehensiveness, feasibility, appropriateness, clarity, effectiveness, innovation, and responsiveness to the needs the core competency requirements of a PCHH; and
* the extent to which the practice demonstrates leadership commitment and basic capabilities that will allow it to effectively operate as a health home and continually evolve as such through practice transformation activity.

Finally, DSS may consider any relevant information about the organization and/or applicable sites known to DSS.

#### Qualifying Applications

DSS reserves the right to reject an organization’s application at any time during the evaluation process if the applicant:

* fails to demonstrate to DSS’ satisfaction that it meets all application requirements, or
* fails to submit all required information or otherwise satisfy all application requirements in **Section 4**.

DSS may determine non-compliance with an application requirement when it is deemed to be insufficient.

**Appendix A**

General Functional Definitions of

Care Coordination and Clinical Care Management Services

 **(adapted from definitions developed by Ed Wagner, MD[[5]](#footnote-5))**

**Care Coordination**

A core function of primary care and Primary Care Health Homes (PCHH) is the delivery of a set of care coordination activities, assuring that patients receive timely, high quality and efficient health care and support services within and outside of the health home through the development and implementation of a care plan and development of patient self-management skills. Services may be identified either by the organization, by the patient, or by other providers to maintain or improve the wellbeing of the patient and includes clinical services, clinical and non-clinical support services available within the community, and facility-based services. To coordinate care effectively, this role involves activities to:

* identify available community resources;
* assure that referrals made by the PCHH for external services result in timely appointments, timely two-way transmission of useful patient information, and address patient and practice concerns without duplication of services or provision of inappropriate services;
* obtain reliable and timely information about external services not initiated by the PCHH such as emergency, patient-initiated, or other provider-initiated care, as well as care management in order to provide and receive patient information, and to assure safe and effective transitions;
* interface with case management or disease management staff functioning on behalf of insurers, disease management companies, publicly funded programs, state agencies, including schools, etc. to assure that services are consistent with the health home’s care plan, and
* provide patient education and self-management support.

#### Clinical Care Management

The clinical care manager has several unique functions, some of which can only be performed by a licensed nurse. The unique activities of the clinical care management role are the identification of high-risk patients, and their more intensive monitoring, follow-up, and clinical management. These activities generally include:

* frequent patient contact;
* clinical assessment;
* medication review and reconciliation;
* communication with treating clinicians, and
* medication adjustment by protocol.

Self-management support is also a critical element in this role. While clinical care managers often take on some of the activities described in the care coordination role, especially related to transitions, their role is primarily clinical rather than administrative. The clinical care manager can be employed by the organization or be contracted through a community-based agency. In either situation, the clinical care manager must be closely integrated within the PCHH team.

Note: The terms “case management” and “disease management” were consciously not used, because both terms are so closely linked to payer-based functions and as such differ from the clinic-based functions described here. In addition, Case management is a term that has specific meanings within several publicly funded health and human service programs. If successfully implemented and operated within the clinic setting, care coordination and care management have the potential for eliminating the need for at least some public and private payer-based case management and disease management functions once clinics are capable of assuming some or all of these responsibilities.

**Patients Who May Be in Need of Care Coordination and Clinical Care Management**

|  | **People Who May Be in Need of** **Care Coordination** | **People Who May Be in Need of Clinical Care Management** |
| --- | --- | --- |
| **Description** | Person or family with low to moderate level of self-actualization who has a current medical condition and/or risk factors needing services or is healthy, but in need of services to prevent diminution of health status. | Person with complex condition or multiple co-morbidities that places him or her at high risk for a future medical or behavioral health ED visit or hospitalization. |
| **Duration of Services** | Temporary, intermittent, or on-going, depending on nature of need  | On-going until sufficient reduction in risk |
| **Examples**  | 8-year old recently diagnosed with autism who needs educational, social, behavioral health and family support | Person with uncontrolled diabetes |
| **Provider Type** | May be provided by trained layperson (parent, family advocate, community health worker), or a health care provider | Must be provided by a licensed nurse |
| **Goal of Services** | To take action to assist the person to remain as healthy as possible by accessing culturally appropriate and necessary care and community-based services and by using services appropriately. | To take action to keep the person safely cared for within the patient-centered health home or across a system of care within the community, preventing ER visits, hospitalization, reduce unnecessary facility admissions, and minimize nursing facility lengths of stay. |

|  | **Persons Who May Be in Need of** **Care Coordination** | **Persons Who May Be in Need of****Clinical Care Management** |
| --- | --- | --- |
| **Focus of Services** | Broadly focusing on medical, psychosocial, educational needs and providing linkage to community services | Primarily a medical focus  |
| **Relationship to Health home** | Physically or virtually located within the clinic. Care coordinator is a member of the health home care team.\* | Physically or virtually located within the Clinic. Clinical care manager is a member of the health home care team.\* |
| **Key Service Functions** | * Care coordination and follow-up
	+ Development of multi-disciplinary care plan, created jointly by the individual or family and the care team, and which the individual or family has access to at all times
	+ Support/facilitate care transitions
	+ Provide linkages to needed community-based services, e.g., behavioral health services
	+ Maintain continuous communication and documentation to assure care team’s knowledge of activities/decisions/issues
	+ Manage/track tests, referrals and outcomes
	+ Assist patient/family with identifying barriers and problem solving solutions
	+ Function as system navigator
* Coach patients/families on self-management skills
* Participate in QI activities at the level of the health home or broader system of care
 | * Coordinate care among providers and across continuum of care
* Population management – identifies high risk patients in need of care management and pro-active outreach
* Intense medical and medication management
* Intense transition management
* Care review and planning:
	+ Complete/analyze medical, biopsychosocial support and self-management support assessments;
	+ Update as necessary
	+ Develop and maintain care plan
* Provide care coordination services to patients receiving clinical care management
	+ Oversee care coordination activities delegated to other team members
	+ Train team members in care coordination and self-management support
 |

\*Organizations and sites might share resources, which could be either dedicated resources or contracted resources from a community agency, such as Independent Living and Recovery Learning Centers for care coordination and/or a home health agency or home care agency for clinical care management.

### Application of Care Management and Care Coordination

### by Population

# Wellness and Prevention &

# Diagnosis and Treatment of Disease

# Care Coordination

**Clinical**

**Care**

**Management**

Appendix B

**Application to be Recognized as a Primary Care Health Home (PCHH)**

Note: The first row of text in italics in the sections below is provided as an example. Enter your information starting in the second rows.

Section A: Organization and Clinic Site Information

|  |
| --- |
| **1. General Information on the Organization** |
| Name, title and address of person completing application: | Email and Telephone: |
| Name and address of applicant organization  | Federal Tax Identification Number (of parent): |
| Name and title of person who will be physician champion/provide physician leadership for PCHH: | Email and Telephone |
| Name and title of person who will be medical director for PCHH: | Email and Telephone |
| **1.A Name and Primary Contact Information for Clinic Site(s) Applying for Participation (insert rows for additional clinic sites as needed)** |
| **Name of clinic site and federal tax ID** | **Address of clinic site:** | **Person overseeing PCHH at clinic site (name and title)** |  **Email** | **Clinic Site Phone:** |
| *Sample: Missouri Valley Clinic* | *45 South Main Street**Kansas City, MO 64147* | *Jane Doe, Clinic Manager* | *Jane.doe@moval.org* | *888-898-8999* |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

|  |
| --- |
| **1.B Provider Detail for Clinic Site(s) Applying for Participation (insert rows as needed for additional clinic sites)** |
| **Name of Clinic Site** | **Name of Clinicians at Clinic Site** | **NPI of Clinicians** |
| *Sample: Missouri Valley Clinic* | *Dr. Mary Smith**Dr. Susan Jones* | *1902049000**1912409000* |
|  |  |  |
|  |  |  |
|  |  |  |

|  |
| --- |
| **2. Payer Detail for Clinic Site(s) Applying for Participation (insert rows as needed for additional clinic sites)** |
| For the clinic site(s) identified above and from the list of payers below, please include the provider number for any insurer with which the clinic(s) has a primary care contract. If the organization has multiple clinic sites that all have the same provider number with a payer, indicate as such.* United Health Care
* Home State Health Plan
* Missouri Care Health Plan
* MO HealthNet
 |
| **Name of Clinic Site** | **Insurers** | **NPI (MO HealthNet) or Provider Number (other insurers)** |
| *Sample: Missouri Valley Clinic* | *Home State Health Plan**MO HealthNet* | *8934567890* *4634567890* |
|  |  |  |
|  |  |  |
|  |  |  |

|  |
| --- |
| **3. Clinic Site Characteristics (insert rows for additional clinic sites as needed)** |
| **Name of Clinic Site**Note: If the applicant has multiple sites with the same status (FQHC or RHC) and same specialty mix, they can be grouped in one row. | **Site Type (e.g., FQHC, Rural Health Clinic, other primary care practice)** | **Specialty (include all that apply)*** **Pediatrics**
* **Family Medicine**
* **Internal Medicine**
* **General Practice**
 | **# of patients identified by org. as qualified to be enrolled in MO HealthNet PCHH\*** | **Year clinic site began providing primary care clinical services** |
| *Sample: Missouri Valley Clinic* | *Rural Health Clinic* | *Pediatrics, Family Medicine* | *75* | *2010* |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

\*based on those meeting diagnosis and Medicaid eligibility requirements

|  |
| --- |
| **4. Clinic Site Clinicians with Patient Panels (insert rows for additional clinic sites as needed)** |
| Please provide totals in full-time equivalences (FTEs) and subtotals by category of clinician in number of people filling those positions, to the extent that the clinic has such personnel and whether the positions are staffed or vacant: |
| **Name of Clinic Site** | **Total Physician FTEs with patient panels** | **Total Nurse Practitioner (NP) FTEs with patient panels** | **Do individual primary care clinicians each have defined panels of patients?*****(Yes or No)*** |
| *Sample:Missouri Valley Clinic* | * *3 physician FTEs with patient panels*
 | * *4 NP FTEs with patient panels*
 | *Yes* |
| *[insert more rows for additional clinic sites]* |  |  |  |
|  |  |  |  |
|  |  |  |  |

|  |
| --- |
| **5. Additional Clinic Site Information (insert rows for additional clinic sites as needed)** |
| Please answer the following questions with information as of the date of completing this application.  |
| **Clinic** **Site****Name** | When a patient calls for an acute visit, when is the third-next-available appointment at the clinic site? | When a patient calls for urgent care, what is availability for an appointment at the clinic site?  | Please list the hospital(s) to which your clinic site primarily admits patients, and answer the two questions to the right. | Does the hospital provide 24 hour notification of inpatient admission?(Yes or No) | Does the hospital provide 24 hour notification of ED visit? (Yes or No) |
| *Sample: Missouri Valley Clinic* | *4 days* | *Within 24 hours* | *Jefferson City General Hospital* | *Yes* | *No* |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

|  |
| --- |
| **6. Medical Records**Please complete the following table for the organization and for each site as applicable. Please include additional tables if this application is for more than 5 sites. |
|  | *Sample: Missouri Valley Clinic* | *Clinic Site Name* | *Clinic Site Name* | *Clinic Site Name* | *Clinic Site Name* |
| When was the electronic health record (EHR) system implemented? | *2008* |  |  |  |  |
| Are the eligible providers at the clinic site qualified for Meaningful Use Stage One? | *Yes* |  |  |  |  |
| - If not, when is this expected to occur?  | *N/A* |  |  |  |  |
| **Is the EHR used:** |  |  |  |  |  |
| -in the exam room during patient visits? | *Yes* |  |  |  |  |
| -to exchange data with external systems (e.g., lab, referral providers)? | *Lab only* |  |  |  |  |
| -for 100% of patient record keeping? | *Yes* |  |  |  |  |
| daily by all providers? | *Yes* |  |  |  |  |
| Is practice productivity level at least within 10% of productivity prior to EHR adoption? | *No* |  |  |  |  |
| Name of EHR vendor and system and version #. | *NextGen version 2017* |  |  |  |  |
| Does the organization utilize an interoperable patient registry to \track and measure care of individuals, automate care reminders, and produce exception reports for care planning? | *Yes* |  |  |  |  |
| Does the organization actively utilize MO HealthNet’s comprehensive electronic health record (CyberAccess) for care coordination and prescription monitoring for MO HealthNet participants? | *Yes* |  |  |  |  |

6a. If you are a Federally Qualified Health Center, is your electronic health record directly connected to Missouri Primary Care Association’s DRVS system? \_\_\_\_\_Yes \_\_\_\_\_No

|  |
| --- |
| **7. Payer Mix Characteristics**Please provide the information requested in the table below for each source of patients by payer type and source of site revenue. Exclude grant revenue. Complete a table for each clinic site. Copy table as needed for additional clinic sites. |
| **Clinic Site Name** | **Payer Name** | **Total Number of Patients in Calendar Year** **2017** | **Total Payments** **Received for Calendar Year** **2017** |
| *Sample: Missouri Valley Clinic* | Commercial Insurance and/or HMO | 1000 | $1,000,000 |
| Medicaid Managed Care | 100 | $100,000 |
| MO HealthNet (Medicaid) | 200 | $200,000 |
| Medicare | 1000 | $1,000,000 |
| Self Pay/Uninsured  | 200 | $50,000 |
| **TOTAL** | 2500 | $2,350,000 |

|  |  |  |  |
| --- | --- | --- | --- |
| **Clinic Site Name** | **Payer Name** | **Total Number of Patients in Calendar Year** **2017** | **Total Payments** **Received for Calendar Year** **2017** |
|  | Commercial Insurance and/or HMO |  |  |
| Medicaid Managed Care |  |  |
| MO HealthNet (Medicaid) |  |  |
| Medicare |  |  |
| Self Pay/Uninsured  |  |  |
| **TOTAL** |  |  |

 **Section B: Health Home Transformation**

**8.** Describe in one page or less the experience of the individuals who provide (a) medical/clinical leadership and (b) administrative leadership at each applicant clinic site for PCHH transformation, what he or she will do to ensure successful PCHH evolution, and his or her understanding of the challenges inherent in practice transformation.

**9.** In one page or less, describe and provide examples of how the organization and its clinic sites will involve patients, families and/or caregivers in the process of defining the elements of a “patient-centered practice.”

**10**. In one page or less, describe and provide examples of how the organization and its clinic sites, working as a team, have developed and implemented innovative or creative solutions to better meet patient needs, solve operational issues, or improve clinical outcomes.

**11.** In one page or less, describe in detail the manner in which the organization will support the clinic site(s) functioning as a PCHH, including:

1. ensuring that supplemental payments made available from DSS will be directly used to support the provision of PCHH services at the practice site;
2. providing of staff or other resources (including at a minimum, information technology staff for activities such as EHR programming, data analysis);
3. providing of resources to ensure spread of PCHH functionality to other care teams that are not part of a the practice team, and
4. identifying the person who would be responsible for ensuring all PCHH staff are adequately trained.

|  |
| --- |
| **12. How often does the clinic site hold regular meetings to discuss clinical issues? (insert rows for additional sites as needed)** |
| **Clinic Site Name** | **Frequency of Meetings (e.g., weekly, monthly, quarterly, annually, never, other.)** | **Who Attends (please include all participants) (e.g., physicians, nurse practitioners, physician assistants, medical support staff, office staff, other.)** |
| *Missouri Valley Clinic* | *Bi-weekly (Tuesdays and Thursdays)* | *Physician, nurse care manager, behavioral health consultant, care coordinator nutritionist, medical assistant* |
|  |  |  |

1. Berwick DM. “What ‘Patient-centered’ Should Mean: Confessions of An Extremist”. *Health Affairs* 28, no. 4, w555-565, published online May 19, 2009. [↑](#footnote-ref-1)
2. See **Appendix A** for definitions of “care coordination” and “Clinical Care Management Services.” [↑](#footnote-ref-2)
3. See **Appendix A** for definitions of “care coordination” and “Clinical Care Management Services.” [↑](#footnote-ref-3)
4. Other use of technology, such as to improve medication compliance and provide remote behavior coaching, represents additional means for enhancing access. [↑](#footnote-ref-4)
5. Judith Schaefer, MacColl Institute [↑](#footnote-ref-5)