GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

September 30, 2020

The District of Columbia's Department of Health Care Finance (DHCF) is pleased to share Health Management Associates' (HMA) summary of experience delivering individualized technical assistance to Medicaid providers participating in the My Health GPS program. Information on the My Health GPS program is provided as context for the report and DHCF's ongoing support for the My Health GPS program, as well as expanded practice transformation assistance for Medicaid providers, is described.

My Health GPS

In July 2017, the Department of Health Care Finance launched the My Health GPS program to deliver care coordination services to Medicaid beneficiaries with multiple chronic conditions. The My Health GPS program is led by multi-disciplinary teams within the primary care setting to coordinate care across medical, behavioral, and social service systems. Covered services include:

- Care coordination,
- Comprehensive case management (CCM),
- Health promotion,
- Comprehensive transitional care,
- Individual and family support services, and
- Referrals to community and social support services.

All participating providers are required to have certified EHR technology and health information exchange services needed to support population health management.

Overall, the program is designed to improve MHGPS enrollees' health outcomes and reduce avoidable and preventable hospital admissions and ER visits. As of June 2020, the My Health GPS program works with 10 providers who collectively serve more than 5,000 enrollees. Early evaluation results are promising, and My Health GPS providers have shared innovative approaches to improve transitions of care and reduce unnecessary re-hospitalizations and ER visits.

Individualized Technical Assistance

In response to feedback from providers throughout the design and early implementation of the My Health GPS program, DHCF recognized the need to support new health home providers participating in the My Health GPS Program. The My Hy Health GPS Individualized Technical Assistance (ITA) contract was developed explicitly to support providers transition to a more team-based, person-centered, and integrated model of care. From inception, the contract was organized around understanding and helping participating providers achieve

improvement across specific aspects of care delivery, formalized as a set of four core competencies for practice transformation:

- Delivering patient-centered care
- Using population health analytics
- Adapting operations to a performance-based model
- Developing leadership to support a value-based payment strategy

Based on a competitive procurement process, HMA was awarded the ITA contract in April 2018. The work was performed over a two-year period from May 2018 to April 2020.

The following executive summary was independently developed by HMA and summarizes HMA's perspective on work conducted under a Department of Health Care Finance contract, the Individualized Technical Assistance (ITA) contract.

The report included the following elements:

- An overview of the technical assistance contract and activities, including a summary of the learning collaboratives and an appendix reviewing the experiences of each of the My Health GPS participating practices.
- Improvements in core-competency attainment by each of the My Health GPS participating practices based on the post-assessment and a summative report of the ITA Program. These are organized by core competency within the DHCF Framework for Practice Transformation.
- Recommendations for continued My Health GPS Program improvement and individualized TA.

Concurrent with HMA's ITA program, the My Health GPS team at DHCF, with clinical leadership from DHCF's Health Care Delivery Management Administration, worked closely with the provider teams to ensure requirements of the My Health GPS program were met. These efforts focused on opportunities to improve clinical workflow, documentation, and care plans.

Over this period the DHCF team also pursued additional policy changes to ensure the program focused on efficient, well-coordinated care delivery of care, rather than administrative reporting. Specific policy updates that have since been implemented are highly responsive to provider-feedback, including:

- Consolidating the My Health GPS staffing model into one acuity tier
- Transitioning payment from monthly to quarterly bundled payments
- Modifying the in-person requirements for the annual biopsychosocial assessment to allow tele-visits when appropriate

In addition, the implementation of pay-for-performance program withholds will be delayed an additional year due to instability in the performance measures, which were not ultimately feasible to use with a new program and small population.

Next Steps

DHCF is committed to supporting whole-person care via care coordination, including health homes, and continues to work with health home providers to revise and improve the effectiveness of the agency's policies and technical assistance. In the fall of 2020, DHCF will announce an expanded Integrated Care TA (ICTA) program to support practice transformation efforts for Medicaid providers in the District of Columbia. The base year of this program will particularly emphasize support for behavioral health providers and efforts to incorporate diagnosis, treatment, and supportive services for individuals with substance use disorder.

Questions about the My Health GPS program, including information on how to become a My Health GPS provider may be directed to Tippi Hampton Stephenson at MyHGPS@dc.gov

HEALTH MANAGEMENT ASSOCIATES

DC My Health GPS Individualized Technical Assistance Program

Executive Summary Of the Final Report

PRESENTED TO
DC DEPARTMENT OF HEALTH CARE FINANCE
APRIL 2020

Introduction

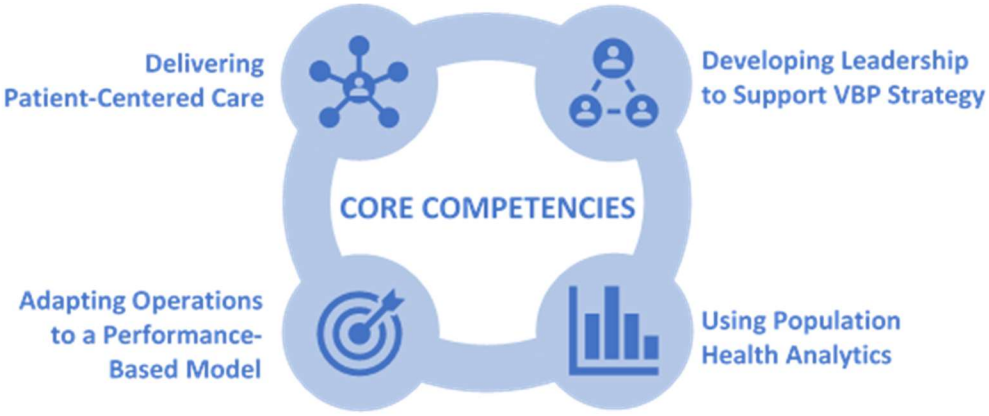
Health Management Associates (HMA) is pleased to submit this executive summary for the final report providing a summary of activities, impact and recommendations for the Individualized Technical Assistance (ITA) contract, May 2018 to April 2020. The report's primary objectives include the following elements:

- An overview of the provision of technical assistance, including a summary of learning collaboratives and an appendix with summaries for each My Health GPS participating practice
- Improvements from the post assessment and a summative report of the impact of the ITA Program by core competency within the Department of Health Care Finance (DHCF) Framework for Practice Transformation
- Recommendations for continued My Health GPS Program improvement and individualized technical assistance

ITA Program Approach and Participating Practices

Starting in May 2018, HMA was contracted to provide ITA to the My Health GPS practices addressing program priorities by identifying gaps and training opportunities both within and across practices. The ITA Program focused on enhancing My Health GPS provider capacity to successfully implement value-based models of care by supporting providers' efforts to re-design care delivery workflow in order to improve quality. The program is based on the DHCF Framework for Practice Transformation, including four core competency learning objectives as outlined in Figure 1.

Figure 1: DHCF Core Competency Learning Objectives for Practice Transformation



The HMA team provided one-on-one technical assistance and group learning collaborative opportunities to the My Health GPS practice teams focused on managing their population of beneficiaries with multiple chronic

conditions. The approach began with on-site practice assessments, followed by development of curriculum plans based on the gaps and priorities identified through assessments, and then the provision of individualized coaching and technical assistance throughout the length of the contract.

ITA Program Participating Practices

- Bread for the City
- Children's National Health
- Community of Hope
- Family and Medical Counseling Service
- La Clinica del Pueblo
- Mary's Center
- Providence Health Services
- Unity Health Care
- Whitman-Walker Clinic

Nine My Health GPS practices participated in individual practice coaching, including Federally Qualified Health Centers (FQHC) and other primary care practices. HMA also provided coaching support to a practice in the recruitment phase and a hospital-based internal medicine practice during the base period.[1] Practices represented a range of sizes in terms of number of providers and staffing models. Individualized coaching sessions with each practice's coach were designed to occur monthly, though they could be more or less frequent depending on the needs of the practice and how those needs evolved over time. Many of these sessions occurred in person, which were particularly helpful for engaging leadership and staff and facilitating working sessions, while other coaching sessions were virtual. Through these sessions, practices and their coaches focused on achieving the practice's individual goals, addressing challenges and barriers faced by the practices. The assessment was repeated at the end of the second contract period (September 2019) to report on the progress practices had made across several metrics.

HMA designed individualized coaching and learning collaborative webinar sessions to support and reinforce each other, with content carrying over from one to another. Often, the webinar would introduce the subject, content, and best practices, then the individualized coaching would demonstrate how the My Health GPS teams could incorporate the information into their practices. HMA delivered 24 virtual and three in person learning collaboratives. Content for these sessions, aligned with the individualized TA, was developed based on identified needs of the practices and reinforced the elements of the four core competencies (see Table 1 for the full list of sessions). Additionally, the learning collaboratives were an opportunity to earn continuing educational credit for many My Health GPS care team members.

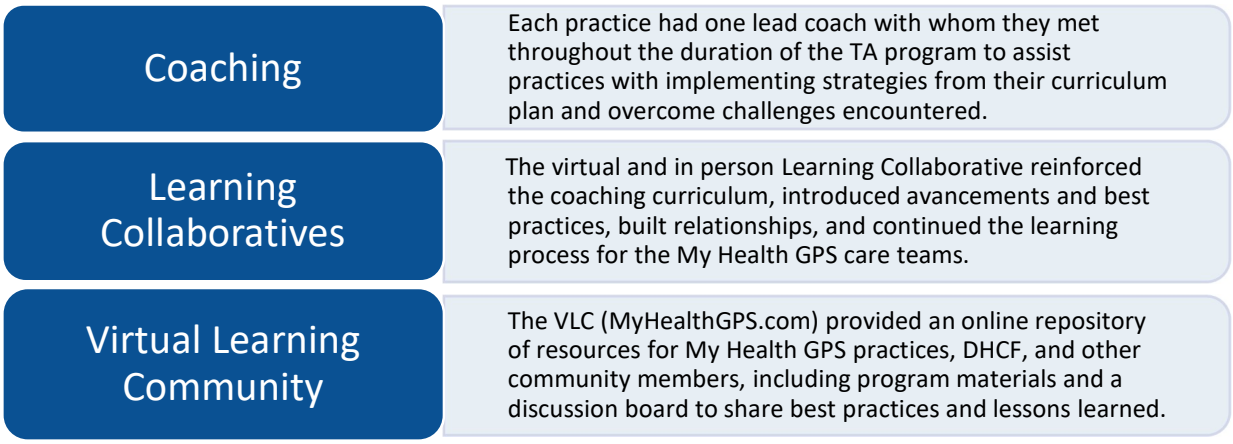
Having access to a coach has been wonderful and keeps us accountable to improve the care management program.
- *Program Director, My Health GPS Participating Practice*

Continuously throughout the ITA Program period, DHCF collaborated with HMA on the development of TA and provided guidance about updates in requirements and payment structure. Clarifications to program policy resulted in the need for quick adjustments in practice priorities and requests for additional coaching support. Coaches addressed these updates, along with curriculum needs based on each practice assessment. Coaches worked with practices to understand and implement additional program clarifications made by the DHCF to care plans, payment structure, and monthly panel reports, frequently reinforcing the dissemination of information throughout the practice teams to make changes to program practices as needed.

[1] These practices were Gerald Family Practice and George Washington University, respectively.

HMA partnered with ZaneNet to support technical assistance related to the use of the Chesapeake Regional Information System for our Patients (CRISP) platform, the District's Designated DC HIE partner. ZaneNet also focused on meaningfully using electronic health records, and the development of the My Health GPS Virtual Learning Community (VLC) website. The VLC provided My Health GPS care teams role-based access to a file and resource repository, on-demand learning collaborative videos and associated materials, a discussion board for collaborating with other practices and DHCF staff, links to relevant tools and external sites with general information and highlights. The VLC content will remain available to practices and DHCF beyond the contract period to support ongoing learning and care team training at https://www.myhealthgps.org/. Additionally, ZaneNet provided valuable knowledge of the DC safety net and, supported the HMA coaches with summarizing and identifying tools and best practices.

Figure 2: HMA's Individualized Technical Assistance Program Elements



HMA coaches worked closely with the My Health GPS care teams to implement care management best practices, with a focus on community level engagement, to improve health outcomes for their complex members. This multi-faceted approach allowed HMA to provide technical assistance and coaching that was tailored to the needs of each practice while leveraging technology to offer learning opportunities that any interested practice could benefit from, so that together DHCF and the My Health GPS practices could reach their goals.

Summary of Improvements and Learnings Across Practices

Nine My Health GPS practices received one-on-one practice coaching and support through the virtual learning community sessions during the two years of technical assistance through the program. A tenth practice participated to a minimal degree in the learning collaboratives and did not receive 1:1 coaching. This practice is not included in the following assessment summary and recommendations.

These efforts demonstrated improvement in providers' competencies for practice transformation, specifically care management practices and the use of health IT for panel management. A summary of ITA Program impact is reported below, first through improvements documented in the repeat assessment and then, for the overall ITA Program two-year contract period according to core competency.

Table 1: Learning Collaborative Sessions, Core Competency Learning Objective, July 2018-April 2020

#	Learning collaborative topics:	Delivering Patient-Centered Care	Using Population Health Analytics	Performance-Based Model	Leadership to Support VBP Strategy
1	Can I Bill for That? Care Management Scenarios			✓	✓
2	What Makes a Good Behavioral Health Referral?	✓		✓	
3	Utilizing Real-Time ADT Alerts for Patient Outreach	✓	✓		
4	Utilizing ADT Alerts for Transitions of Care		✓	✓	
5	Patient Engagement (Part 1)	✓			
6	Stepped Behavioral Health Care in Primary Care	✓		✓	
7	Strong Patient Engagement Depends on Strong Teams (Part 2)	✓		✓	✓
8	(In-Person) My Health GPS Leadership Workshop: Deep Dive into Strategies for Success		✓		✓
9	Best Practices in My Health GPS Care Management	✓			
10	Quality (Part 1): Utilizing Quality for Program Improvement			✓	✓
11	Quality (Part 2): Using CRISP/CAliPR Quality Tools		✓	✓	
12	How to Set Up and Use a Telehealth Program in MHGPS		✓	✓	
13	Addressing Unstable, Unsafe, or Unhealthy Housing in the My Health GPS Program	✓			
14	Case-Based Learning: My Health GPS Member Case Study	✓	✓	✓	
15	Health Literacy in a Care Coordination Context	✓			
16	Transitions of Care Post-Hospitalization		✓	✓	
17	Back to Basics: Revisiting Care Team Best Practices to Address Transitions of Care			✓	
18	Shaping the Future of HIE in the District		✓		
19	(In-Person) Celebrating Successes and Planning for the Future				✓
20	MHGPS Patient Engagement and Retention	✓			
21	Diabetes Management in the MHGPS Population	✓	✓		
22	Person-Centered Care Planning in the My Health GPS Program	✓			
23	Enlightened Leadership and High Functioning Teams			✓	✓
24	(In-Person) My Health GPS Provider Workshop				✓
25	Substance Use Disorders: Screening and Assessment for the My Health GPS Population	✓			
26	Telehealth Implementation Basics and Payment Updates for COVID-19			✓	✓
27	Treatment of SUD in the Setting of COVID-19 with a focus on Telehealth and MAT	✓		✓	
	Total by Core Competency	**14**	**9**	**14**	**8**

My Health GPS Practice Improvements Reported through the Assessment Process

The HMA coaches worked with the My Health GPS practices to perform an initial evaluation of program implementation using an assessment tool in July and August of 2018. HMA developed the assessment based on the three domains described in the ITA contract language. The elements within each domain are aligned with practice transformation core competencies, which became the more agreed upon language during the contract period.

The HMA coach worked with each care team to complete the initial assessment over several visits. The practices received and reviewed the findings for accuracy. The gaps identified during this process were used to create the coaching curriculum for each practice. Additionally, the aggregate findings were used to inform the curriculum for the group learning sessions such as the webinars and learning collaboratives. Then, in August 2019, the coaches and the practice teams worked together to discuss and make updates to the assessment tool to record progress over the past year. Compared with the baseline practice assessments conducted during the initial site visits, the MHGPS practices in aggregate showed improvement across the three assessment domains as shown in the table below. The assessment tool included questions with a variety of tiered answers, some with yes or no options and others with three to four options to demonstrate detailed levels of implementation. The highest level of implementation is defined as reporting full program implementation for a certain element within the assessment tool.

Summary by Core Competency

The goal of the My Health GPS Program is to create value for individuals beyond clinical care, by incorporating elements of value-based payment and strength-based, person-centered care delivery. The ITA Program supported provider practices to develop the infrastructure needed to accomplish systemic transition. Below is a summary of improvement by core competency, including successes and challenges.

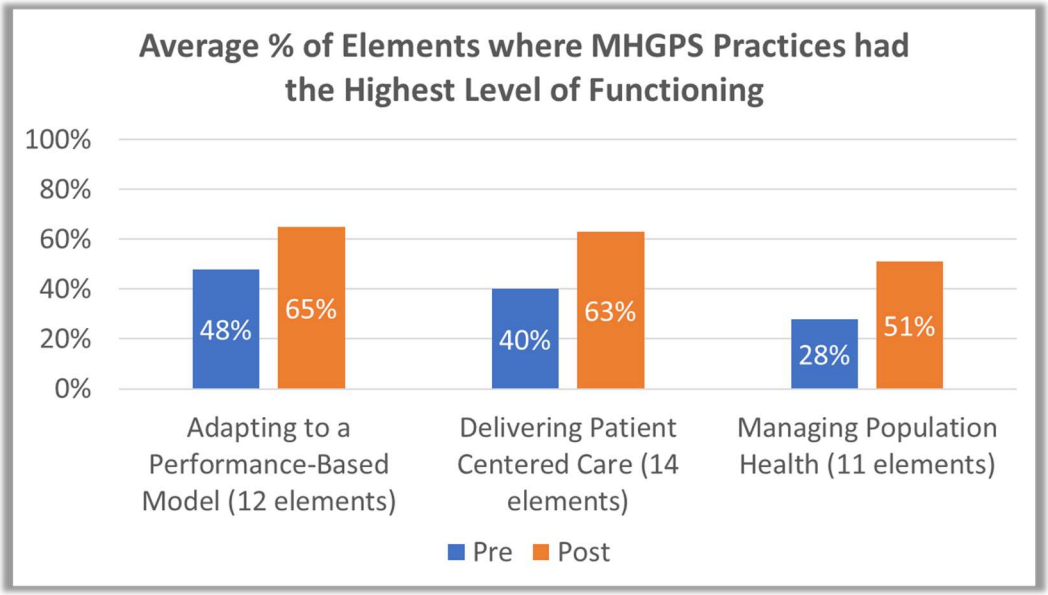
CORE COMPETENCY 1: DELIVERING PATIENT-CENTERED CARE

HMA provided technical assistance to My Health GPS practices delivering patient-centered care, including coaching to optimize workflows to employ best practices to support prioritizing beneficiaries for needs assessment, care plan completion and updates, and personalizing plans of care with both internal and external referral services.

My Health GPS practices showed **moderate improvements** in this core competency. Main takeaways include:

- All practices use goal driven in-person biopsychosocial (BPS) assessment and care plans that address social determinants of health and their barriers to care.
- Many practices improved the care plan process. Examples included development of workflows, templates, and bi-lingual care plan summaries; enhancement of care planning tools in the electronic health record; and staff training on goal-driven care planning and care coordination.
- Through enhanced tracking, practices showed improvements in maintaining or increasing their monthly touch rate. In general, a 70-80% touch rate is needed to “break even” in the program, though this varies depending on maintaining required staffing ratios, maximizing caseloads and staff salaries. As such, many practices were striving for a 70-80% touch rate, or for a notable improvement based on their current touch rate. Practices with lower initial performance in touch rates demonstrated improvement in the contract period, while practices with higher comparative touch rates were able to maintain their high rates with relative consistency in the same time period.

Chart 1: My Health GPS Practice Improvement on Competency Elements



(*See appendix A for a description of each of the Elements)

- Seventy percent of practices demonstrated a net gain in enrollment during the ITA Program period. This was especially evident in practices with more concerted enrollment campaigns. Overall, the number of members enrolled in the My Health GPS Program showed a net increase of 20% during the ITA Program period.

CORE COMPETENCY 2: USING POPULATION HEALTH ANALYTICS

Throughout the entire My Health GPS ITA engagement, using data and integrating the various tools available to practices into workflows remained a key focus area. Every practice received specific coaching related to population health analytics, quality measurement, patient-level data, operations and accountability data. DHCF provided training for the providers to address the educational needs for the topics listed below. In addition to this training provided by DHCF, CRISP, and the HMA individual practice coaching, the practices joined monthly Learning Collaboratives. Population health analytics was a topic covered in both HMA and DHCF sponsored trainings.

My Health GPS practices demonstrated **significant improvements** in this core competency. Main takeaways include:

- All participating practices have been trained on and used the Patient Snapshot, ENS, Clinical Query Portal and had incorporated the tools in their data workflows in a purposeful way.
- The majority of practices developed spreadsheets or developed reports from their EHR to track touch rates and care plan anniversary dates. These data made it possible for all practices to model their enrollment, touch rate, and staffing to identify engagement, outreach and enrollment targets, with the assistance of their coach.
- All practices were trained and had established connections to CAliPR in order to track their My Health GPS Pay-for-Performance Incentive Program measures as well as other clinical quality measures. Practices were also provided with demonstrations of HealthEC in order to perform additional utilization and cost-based population health analytics.

- Practices actively communicate and collaborate around priority metrics across practices. Despite the delayed launch of the pay for performance program, practices continue to apply skills developed specific to population health analytics and performance and quality measurement concepts and processes.

CORE COMPETENCY 3: ADAPTING OPERATIONS TO A PERFORMANCE-BASED MODEL

HMA technical assistance to adapt My Health GPS practice's operations to a performance-based model included practice-specific coaching and group learning collaboratives to assist new and experienced Care Managers in developing and refining their skills and tactics, avoid burnout, develop and implement workflows for technology integration and care transitions, continuous quality improvement, advance team-based models and telemedicine.

The practices demonstrated **significant improvements** in the core competency of adapting operations to a performance-based model. Main takeaways include:

- Practices demonstrated improvements with respect to the basic tenets of high functioning care teams, including written position descriptions, after-hours availability and secure communications.
- Practices evaluated and improved staffing models, either to ensure that ratios of beneficiaries/staff were maximized (i.e., via increased enrollment) or to ensure that new staff were properly trained and the My Health GPS Program continued to run seamlessly with the addition of new team members.
- Practices continued to refine processes to support transitions of care post-hospitalization and ER visit, but few have evolved to providing service delivery beyond their practice walls, therefore system-wide impact is limited.

CORE COMPETENCY 4: DEVELOPING LEADERSHIP TO SUPPORT VBP STRATEGY

HMA provided technical assistance to My Health GPS practices developing leadership to support a value-based payment strategy throughout the ITA Program. This competency was more specifically emphasized during the second half of the ITA Program to build upon improvements made within the other core competencies. The TA approach included the development of tools and provision of trainings on management and leadership skills, program-specific financial analysis, and applications to value-based payment and alternative payment models across care coordination initiatives. HMA repeatedly emphasized that effective care management of individuals eligible for My Health GPS will facilitate success in shared savings opportunities being offered by health plans and the DC FQHC-specific alternative payment methodology.

My Health GPS practice **progress varied** in this core competency. Main takeaways include:

- Care teams and My Health GPS Directors learned to use tools, evaluate high value interventions and target efforts toward more cost-effective activities.
- Practices reported increased practice leadership engagement to support the My Health GPS team and their activities. However, some practices demonstrated more leadership buy-in than others.
- Developing leadership support was more challenging in practices with low My Health GPS beneficiary enrollment numbers.

Recommendations for the Future

Through the collaboration between DHCF and HMA in the ITA Program, the My Health GPS practices made substantial progress over the past two years. The My Health GPS Program continues to evolve to align with District-wide priorities and to incorporate practice feedback. DHCF staff contributed to transformation and policy efforts during the ITA Program period. Ongoing support and collaboration from the DHCF will ensure program longevity, continued improvements to implementation, and expansion of care coordination beyond this important building block to promote new models of care within the District. Health Management Associates makes the following recommendations for focused areas of program improvement and growth.

Integrate My Health GPS into the broader practice

Many of the aspects of effective care management and delivering patient centered care are applicable to managing the physical and behavioral health conditions of the other beneficiaries with chronic conditions who are not receiving MHGPS services at the MHGPS participating practices. The My Health GPS Program would be better positioned for long term sustainability if it is more ingrained in the overall operations of the health centers rather than a siloed program. *HMA recommends the practices continue to receive communication and support on how to integrate the My Health GPS Program into overall operations rather than considering the program to be a separate cost center*.

Understand more about the limitations to practice and member participation

To increase ongoing enrollment, care coordination activities, and impact population health, DHCF should continue to investigate the program limitations to both practice and member participation. DHCF can use this information to consider further recruitment strategies and to have an early identification of at- risk MHGPS practices. *HMA recommends DHCF take the following actions to engage past practices and enhance current practice participation:*

- *Perform a survey or assessment of current and past My Health GPS practices to learn more about My Health GPS effectiveness, including successful strategies, to inform program updates, future outreach, enrollment and care coordination strategies to enhance and expand the program.*
- *Continue to re-evaluate payment structure and implement changes to include more value-based incentives. Accelerate the efforts to develop the Pay for Performance strategy.*

Continue to support My Health GPS practices through various forms of technical assistance

The My Health GPS practices will continue to benefit from technical assistance focused on program requirements and re-enforcement of care management best practices for specific disease needs prevalent to this patient population. Regular and ongoing technical assistance provides a level of accountability and venue for communication to support both DHCF and practice program goals, while also building partnerships and will for continued participation. *HMA recommends DHCF take the following actions in terms of providing technical assistance to My Health GPS practices:*

- *Determine methods for the DHCF team to continue to provide individual technical assistance to practices. Options could include monthly or quarterly check-ins, practice workgroup support, topic-specific webinars, bi-annual in-person program convenings.*

- *Maintain the DHCF or My Health GPS website to offer updates, resources, and a helpline for timely response on program issues.*

Connect the My Health GPS Program and practices to the larger District-wide vision and community

DHCF should consider methods to continue to connect the My Health GPS to the broader planned reform efforts and goals of comprehensive care coordination, especially considering moving additional populations to managed care. My Health GPS gives managed care organization (MCO) care managers boots on the ground at primary care practices to collaborate in terms of health risk assessments, transitions of care and other tasks as extended members of the interdisciplinary care team, taking advantage of the opportunity to develop face-to-face trusting relationships.

HMA recommends DHCF take the following actions in terms of connecting the My Health GPS Program to District-wide care coordination and population health initiatives:

- *Create expectations of Medicaid MCOs that they will contract with My Health GPS practices for a care coordination fee for members assigned to a primary care provider affiliated with that practice with aligned but modified metrics and fees to reflect the lower complexity of that population.*
- *Leverage relationships and contracts to facilitate communication between MCO care managers and the My Health GPS care team, reduce the potential for duplication of care management tasks, and align incentives and workflows between care team and MCOs.*
- *Investigate options to assist My Health GPS practices with member outreach through a broad, integrated, and centralized approach, especially focused on members not currently engaged with a My Health GPS practice.*

Appendix A

My Health GPS Practice Assessment Tool- elements of the assessment

The HMA coaches worked with each care team to complete both the pre and post assessments. After the practices received and reviewed the findings for accuracy, the HMA coach used the identified strengths and gaps to create the individualized coaching curriculum for each practice. The aggregate findings were used to inform the curriculum for the group learning sessions such as webinars and learning community presentations and discussions.

HMA developed the practice assessment based on the domains described in the ITA contract language. The elements within each domain are aligned with practice transformation core competencies, which became the more agreed upon language during the contract period. The core competency framework was utilized to describe the reassessment results.

The domains and elements are listed below. For each element, there were multiple choice responses which culminated in a score for each category. Along with the individual site reports, the practices received information on how each of their responses compared to the aggregate.

DOMAIN 1: Adapting to a Performance-Based Model:

TEAM MEMBERS There is an identified MHGPS Care Management Team:

- Health Homes Dir
- Nurse CM (APRN or RN)
- Peer Navigator
- Care Coordinator (for group 2)
- Licensed clinical pharmacist (for group 2)

FUNCTIONS OF THE CARE TEAM

- Staff integration: MHGPS Care team members are blended/share roles and responsibilities with the rest of the clinic staff or have overlapping responsibilities therefore avoiding silos, creating efficiencies and maximizing FTEs.
- Care team members can interact regularly with the primary provider(s).
- MHGPS Care team members have written position descriptions; or MHGPS responsibilities have been added to existing position descriptions
- A MHGPS care team member is available to provide 24/7 access to clinical advice, after hours and weekends for calls from beneficiaries or facilities regarding transitions of care AND these interactions are documented in the medical record.
- The care team has communication strategies such as messaging after hours and weekend. They can communicate securely and remotely.
- The care team includes, or has immediate and direct access to behavioral health staff including warm hand offs, referrals or consultations

- Processes are in place to ensure that care management staff are properly trained at hiring and at regular intervals. Other practice staff are educated on the role of the CM/CC, and their roles in interacting with the care team.
- Care coordinators/peers are highly mobile into the community- they can meet beneficiaries in their homes, shelters, at the hospital/ED or accompany a beneficiary to a physician office visit.
- All care team members, including BH staff, document in a shared medical record.
- The care team has a schedule or system for dedicated time to meet to discuss complex and high-risk beneficiaries (case reviews).
- Clinic/practice leadership is engaged in or supports the MHGPS program; they understand the value proposition and are engaged in program sustainability
- Team/practice can identify and address provider and staff burnout in regard to managing high needs, complex populations.

DOMAIN 2: Managing Population Health; including CRISP tools and quality reporting

USING TECHNOLOGY SOLUTIONS TO SUPPORT CARE MANAGEMENT

- All encounters are entered in to the EHR for tracking, accountability and care coordination purposes.
- EMR clearly identifies MHGPS members (such as pop-up; banner; special label, etc.) so all staff will recognize the special status of this beneficiary at any point of service.
- Receive and act on ENS/ADT feeds: The care team can receive real time alerts (ADTs) when a beneficiary has been admitted/discharged or transferred.
- The IT systems (EMR or data warehouse) can create an electronic registry of attributed MHGPS members.
- IT systems (EMR) can produce report on MHGPS cohort attributed to your clinic; report can identify disease prevalence of common conditions; can track indicators over time and can drill down to individual beneficiaries in order to identify gaps in care.
- MHGPS Care Team uses CRISP Patient Care Snapshot
- MHGPS team uses the CRISP Clinical Query Portal.
- The My Health GPS team uses the CQM Aligned Population Health Reporting (CALIPHR) Tool.
- The Care team receives a report on quality metrics for the MHGPS panel
- A process is in place for billing encounters and tracking payments.
- The practice electronically shares data outside of their organization

DOMAIN 3: Delivering Patient (Beneficiary) Centered Care

BIOPSYCHOSOCIAL NEEDS ASSESSMENT

- Comprehensive biopsychosocial needs assessment Conduct an in-person comprehensive BPS needs assessment to collect behavioral, primary, acute and long-term care information from the member.

CARE PLAN

- Use a person-centered plan of care that reflects the beneficiary's unique cultural needs and is developed in a language or literacy level that the beneficiary can understand, which is documented and maintained in the My Health GPS provider's certified EHR system
- The care plan is reviewed and updated regularly (annually, following a change in status or within 15 days following an unplanned inpatient stay)
- The care plan addresses social determinants of health and their barriers to care such as unstable housing, food insecurity, unemployment, lack of transportation. -
- The plan is shared with all team members and with the beneficiary/care givers; beneficiary contributes to and agrees to the goals; and beneficiary receives a copy.
- All team members can contribute and update the care plan.

BEST PRACTICES

- MHGPS team has created documentation such as p/p and workflows for CC/CM tasks
- Care team RNs have standing orders for selected services such as vaccines, lab draws, and referrals for community services.
- Care Coordination- providing appropriate linkages, referrals and coordination with needed services and supports
- Health Promotion: health education to the beneficiary, family members and caregivers; as identified in the care plan
- Comprehensive Transitional Care- planned coordination of transactions between providers and settings in order to reduce inpatient admissions, readmissions and length of stay.
- Individual and Family Support Services- assist beneficiary and support network in identifying and meeting the beneficiary's biopsychosocial needs and accessing necessary resources as identified in care plan
- Referral to community and social support services: connect beneficiaries to resources to help them overcome access or service barriers, increase self-management skills and achieve overall health as identified in the care plan; ensuring referral is completed.
- Care managers have translation resources (such as telephonic interpreters) to communicate with non-English speaking beneficiaries.
- Provide 24/7 access to clinical advice, including culturally appropriate translation and interpretation services for beneficiaries with LEP.