**Care Planning: NCQA PCMH Care Plan Elements and OHIC Care Plan Elements and Health Plan Expectations**

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| **Element** | **NCQA PCMH 2017** | **OHIC (for high risk patients)** |
| Comprehensive health assessment | Core: Select 6  Family/social/cultural characteristics  Social Functioning  Communication Needs  Medical History of patient and family  Advance Care planning (N/A for pediatric )  Behaviors affecting health  Mental health/substance use history of patient and family  Social determinants of health (new)  Additional Criteria:  Addresses health literacy  Screening adults and adolescents:  Depression, anxiety and SUD  Pediatrics: Developmental screening | Care manager completes a patient assessment based on patient’s specific symptoms, complaints or situation including the patient’s preferences and lifestyle goals, self-management abilities and socioeconomic circumstances that are contributing to elevated near-term hospitalization and/or ED risk  For children and youth:  A family status and environmental assessment (medical/behavioral/dental/ social supports of family/friends/financial needs, family demands /relationships and functioning; cultural beliefs and values of family; strengths/assets of child, youth, family/caregivers and current goals of child/youth and family and  A growth and development assessment of developmental progress/status/child/youth strengths/assets/school performance and needs and emotional and behavioral strengths and needs |

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| **Element** | **NCQA PCMH 2017** | **OHIC (for high risk patients)** |
| Uses comprehensive health data to implement needed interventions, tools and supports for the practice as a whole and for specific patients | Advanced Criteria:  Documents social determinants of health, monitors at population level and implements care based on this data |  |
| Medication safety | Core:  Reviews and reconciles medications for more than 80% of population  Assesses understanding of meds for more than 50% of patients/families/caregivers  Assesses patient response to medications and barriers to adherence for more than 50% of patients  Maintains up to date medication list (new)  Additional criteria  Educates on new prescriptions  Documents nonprescription medications  Advanced  Medication reconciliation for behavioral health (new)  Systematically obtains prescription claims data to assess and address medication adherence. 9new) | Care manager completes a medication reconciliation after a high risk patient has been discharged from inpatient services; to the extent possible the medication reconciliation is conducted in person |

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| **Element** | **NCQA PCMH 2017** | **OHIC (for high risk patients)** |
| Care Support | Additional criteria  Provides educational materials and resources for patients including online support programs (new)  Provides oral health resources (new)  Provides self-management tools to record self-care results  Adopts shared decision aides for preference sensitive conditions (new)  Offers or refers patients to structured health education  Works with community schools or urban intervention agencies 9new) | Care manager provides health and lifestyle coaching for high –risk patients designed to enhance the patient’s caregiver’s self/condition-management skills  Care management/care coordination resources have in-person or telephonic contact with each high risk patient at intervals consistent with the patient’s level of risk |

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| **Element** | **NCQA PCMH 2017** | **OHIC (for high risk patients)** |
| Risk stratification | Core: Selects 3  Behavioral health condition  High cost/high utilization  Poorly controlled or complex conditions  Social determinants of health  Referrals by outside organizations  Advanced  Comprehensive risk stratifications of entire patient panel to direct resources appropriately and provide care planning and management to patients that would most benefit | Practice has developed and implemented a methodology for identifying patients at high risk for future avoidable use of high cost services  Updates the list of high risk patients at least quarterly  Practice has developed a risk assessment methodology that includes at a minimum consideration of  Assessment of patients based on co-morbidity  Inpatient utilization  ED utilization  Practice has a designated resource (RN or LPN or social worker) to provide care management focused on providing services to high risk patients  Practice has a methodology of the timely assignment of levels of care management/care coordination services needed by high risk patients based on risk level, clinical information including disease severity level and other characteristics |

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| **Element** | **NCQA PCMH 2017** | **OHIC (for high risk patients)** |
| Care Plan development | Core:  Identifies treatment goals in individual care plans  Provides written care plan to patient/family/caregiver  Additional Criteria for individual care plans  Incorporates patient preferences and functional /lifestyle goals i  Assesses and addresses potential barriers to meeting goals in individual care plans  Includes a self-management plan  Collaborates with patient/family to develop/implement a written care plan for complex patients transitioning from pediatric to adult  Advanced  Follow s up on community referrals to determine impact on individual patients (new) | Within 2 weeks of completing assessment, care manager completes a written care plan that includes  Medical/social summary  Risk factors  Treatment goals  Patient-generated goals  Barriers to meeting goals  Action plan for attaining patient’s goals  Updates care plan on a regular basis based on patient needs to affect progress to meeting existing goals or to modify an existing goal but no less frequently than semi-annually |
| **Element** | **Health Plan Phase 2 NCM /CM reporting** |  |
| NCM/CM status | Open: date referral received  Participating: Date of engagement when patient consents to participate  Closed: date discharged  Closed reason: expired, declined, unable to contact, goals met, LTC resident, Inappropriate for CM |  |
| **Element** | **Health Plan Phase 2 NCM/CM reporting** |  |
| Intervention Type | Complex: 60+ days of CM  Transition of Care/Moderate: Requires 30-59 days  Short term: /one time touch: Will not require CM after addressing immediate need |  |